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**SOCIAL CLASS AND HEALTH EDUCATION: THE
IMPACT OF CLASS POSITION ON WOMEN'S
EXPERIENCE OF RECEIVING HEALTH EDUCATION
INFORMATION WHILST IN HOSPITAL**

L. E. Henshaw

MPhil

2000

ABSTRACT

SOCIAL CLASS AND HEALTH EDUCATION: THE IMPACT OF CLASS POSITION ON WOMEN'S EXPERIENCE OF RECEIVING HEALTH EDUCATION INFORMATION WHILST IN HOSPITAL

This study aims to explore the impact of class position on women's experience of receiving health education information whilst in hospital for hysterectomy. Evidence from past studies (Webb and Wilson-Barnett 1983, Webb 1986, Bernhard 1992) indicates that lack of information features highly when women talk about their experiences of hysterectomy. However, they have not explored the different experiences of women according to their class position.

A qualitative approach, taking a feminist standpoint and focussing on subjective meanings, was adopted to address the research question. In-depth interviews were conducted with quota samples of thirty six women. Semi-structured interviews were conducted with doctors and nurses to provide a background to the study.

Emerging themes indicate that women from differing class backgrounds have varying informational needs. Working class women accept a passive role and relinquish control over their body to the doctor who they perceive to hold all the power. They express dissatisfaction with the information they receive for dealing with their own recovery. They expect to gain this information from nurses, but find that it is not forthcoming. However, they are reluctant to be critical of nurses who they perceive to be too busy to provide this information.

Middle class women are not satisfied with the information they receive. They express expectations of a mutualistic relationship with their doctors and are disappointed when this is not the case. They also express disappointment when information about recovery is not forthcoming from nurses. They express a need for an opportunity to discuss their anxieties as well as gaining procedural information.

Patient education needs to be taken on board by health professionals as a necessity rather than an luxury. It needs to be addressed in term of equity rather than treating women as a homogenous group with the same needs. Nurses are in the unique and challenging position of spending most time with the patient and should be maximising the opportunity for providing health education .

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INTRODUCTION

The aim of this study is to explore the impact of social class position on women's experience of receiving health education information whilst in hospital for elective surgery. Poor communication between health professionals and their clients has been reported as a major source of dissatisfaction in health care over the last thirty years (Cartwright 1964, Ley 1982, William and Calnan 1991, Bruster *et al* 1994). Patients who are at the lower end of the social class gradient fare even less well in gaining information from doctors (Tuckett *et al* 1985, Street 1991), and yet there is well documented evidence to suggest that those in the lower classes will be in greater need of health care than their middle class counterparts (Black 1980, Whitehead 1992, Acheson 1998). Women are more likely to use the services than men because of their experience of higher morbidity and in their role as carers, responsible for the health of their families and the provision of unpaid care to sick relatives. In the current climate of early discharge from hospital and increased emphasis on care in the community information giving must be considered an essential part of patient care.

Past studies indicate that there is a variation in the quantity and quality of information patients receive according to their social class position (Tuckett *et al* 1985, Street 1991). Kirkham (1989) observed that midwives gave less information to women in lower classes. In the same study midwives indicated a belief that women in lower social classes had less informational needs because they were less intelligent. Patients have expressed discontent with the information they receive about their diagnosis, treatment and recovery, and doctors have been accused of maintaining dominance over control of information and decision making (Porter 1990).

Over the last three decades, social class differences have been found in measures of both

mortality and morbidity. Those at the lower end of the social class gradient have approximately twice the chance of dying at any age than those at the top (Black 1980, Whitehead 1992, Acheson 1998). Manual workers report more illnesses of all types than non-manual workers with differences widening in the older age groups (OPCS 1989).

Though women enjoy a more favourable mortality experience than men, there is evidence that they suffer more ill health. Because women live longer they are more likely to suffer more ill health associated with old age. Statistics from general practice in Britain indicate that women visit their GP on average six times a year compared with four times for men (OPCS 1989). In the USA, Vebrugge, (cited in Turner 1995 p108) provides evidence that women obtain more prescriptions for medicines than men and have twice as many visits to the doctor and hospital.

Women not only use the health service more than men but they also play a major role in the delivery of health care. It is generally implied that professionals produce services and people consume them, whereas in fact the most important producer of health is the person himself or herself (Oakley 1993). Stacey (1994) argues that in the health care system the producer and the consumer are one and women in particular are responsible for the health of their families.

Traditionally it has been the responsibility of women to keep their family healthy and to carry out health promoting activities within the home. Recent health care policy (DoH 1992) emphasises the individual's responsibility for their own health. However, individuals are not only held responsible for their own health but also for the health of others as unpaid or informal carers. They remain the major providers of health care as well as being the principal users of health and medical care (Oakley 1993).

Historically women's health has been very much linked to female sexuality. It has been the target of religious and magical practices and women's bodies have been treated as threatening to the moral and social stability of society. The concept of the hysterical woman was an important feature of nineteenth century medical culture. The term 'hysteria' derived from the Greek word 'hystera' meaning uterus or womb. Hysteria was regarded as unique to women, and women were considered to be emotionally unstable for biological reasons. It was believed

it had physiological roots in the malfunctioning of the womb, hence the treatment for hysterical women in the mid-nineteenth century was hysterectomy.

The theory of hysteria expressed a view of women as patients dominated by male ideology. Assumptions that women's problems could be 'cured' by removal of the womb led to a narrow definition of women. Oakley (1985) describes the 'reproductive medicine machine model' of women, in which the body-mind connection is so close that they can only be described in terms of their uterine physiology and claims that this has remained a dominant theme in the feminine stereotype.

Despite the demise of the Greeks the notion that women are emotionally unstable for biological reasons has remained prominent. It is argued that medical ideology has continued to constitute women as psychologically and socially vulnerable and in need of medical surveillance, advice and guidance (Ehrenreich and English 1978). In modern times normal biological processes such as menstruation, pregnancy and the menopause have been re-framed as medical problems. Reproduction has been medicalised and women are seen as natural patients in a medical culture which emphasises the health problems of women.

Women are the focus of reproductive health care, but concern has been expressed at the shortcomings in the relationship between women and health professionals concerning communication (Porter 1990). Previous research (Oakley 1980, Webb & Wilson-Barnett 1983, Webb 1986, Kirkham 1991, Porter 1990, Bernhard 1992,) has indicated that the quality and quantity of interaction between women and health professionals has been unsatisfactory.

Women's experience according to class position is the focus of this study. Women suffer more ill health than men, are responsible for maintaining the health of others and their reproductive health has been a focus both historically and in current medical culture. Concern has been expressed about their relationship with health professionals over issues of information giving and decision making. Studies of women to date have not focussed on variations between women of differing class positions. However, studies of both men and women indicate that those from working class backgrounds receive less information from doctors. As women are

not a homogenous group, how does their position in society affect their experience of communicating with health professionals?

During the 'Thatcher years' the patient was re-defined as a consumer and it is questioned whether this could challenge the traditional doctor patient relationship. This recent health care policy envisages patients ceasing to be passive recipients of care. Increased patient rights aim to encourage patient-centred practice with increased emphasis given to a multi-professional approach to health care.

The rhetoric of consumerism that has emerged with recent health care policy may have implication for the patients in terms of gaining information from health professionals and their role in decision making. Will it however be the same experience for women from all walks of life, or do women from a middle class background have different needs and experiences to those from working class backgrounds? The aim of this study then is to explore the experiences women have of receiving health education information according to their class position in society.

Women undergoing hysterectomy were chosen because of the nature of the surgery. Hysterectomy is elective surgery allowing time for preparation, and women undergoing it can expect a full recovery. The convalescence period ranges from eight to twelve weeks and during this time there is some restricted activity with a gradual return to normal. Past studies of women undergoing this particular type of surgery (Webb and Wilson-Barnett 1983, Webb 1986, Bernhard 1992, Haas and Purezt 1992) have indicated, however, that women are dissatisfied with the information they receive about their surgery and about coping with recovery.

In order to gain knowledge of women's experiences from their perspective, it was necessary to approach this study using a qualitative methodology. I did not want to make assumptions about whether women wanted information, their understanding of information or their ability to utilise any information they may be given. It was therefore essential to capture the reality of the experience from the viewpoint of women from working and middle class backgrounds.

In traditional quantitative research the format for presentation is theory, followed by data analysis and then discussion. However, the separation of results and discussion does not lend itself to commentary (Taylor 1996) which is required in ethnographic research. Therefore, using this formula for a qualitative methodology is not appropriate or can be difficult to express. In qualitative research the theory, data generation and analysis are developed simultaneously. The sequence of chapters in this thesis will, therefore, reflect that process.

Chapter one will begin by providing a background to the study with a review of the literature. There will then be a discussion of the social context of the study outlining the culture of health care in the mid-nineties , and the events and structures that may have influenced the women's experiences. Chapter one will conclude with a discussion of the concept of social class and the method of assessing class position in this study will be explained. Chapter two will address the methodological issues of the study. Chapter three will include the data analysis and discussion simultaneously. Chapter four will provide the data analysis generated from the interviews with health professionals and is to be seen as a background to the major part of the study. Chapter five will conclude the thesis with a synthesis and attempt to draw some conclusions from the study, it will also include a critical reflection of the methodology, and a discussion of implications for practice.

CHAPTER ONE

LITERATURE REVIEW

Introduction

Communication between patients and health professionals is attracting an increased amount of attention. Information giving is highlighted as a right in the Patients Charter (DoH 1991) and patient education is increasingly being recognised as an important part of the health professional's role. Patients are spending less time in hospital and information about their condition, treatment and coping with convalescence is essential for them to be able to manage their recovery.

The purpose of this literature review is, firstly, to define health education information. Past studies, from both sides of the Atlantic, will then be reviewed to determine what sort of information patients require and who they want to receive that information from. Patient satisfaction with information giving will also be reviewed and any factors which enhance or hinder this will be discussed.

Health Education Information

Health education is a term often used interchangeably with health promotion (Close 1988, Latter *et al* 1992) and as such has caused some confusion. Rawson and Grigg (1988), in a nationwide study of the training and development needs of health education officers, were unable to differentiate between the activities of health educators and health promoters. Tones (1990) offers an operational definition where health education is a complementary element of health promotion. While Rawson (1991) states that most writers have now

redefined health education as part of health promotion, Gott and O'Brien (1990) found the use of the term health promotion in the academic literature meant both health education and communication.

Delaney (1994) defines health education as including any education associated with health, including primary, secondary and tertiary patient education. Though, the use of the term 'patient education' further confuses the issue. Tones *et al* (1994) note that patient education is usually more specific while health education is of a more general nature, but questions if this is an appropriate distinction to make if a holistic approach to care is adopted.

Health education was put forward as a main theme in the Health of the Nation (DoH 1992) document. This strategic paper produced when the Conservative Government was in power emphasised individual responsibility for health in preventing disease and illness. Critics have argued that it amounted to 'victim blaming' by putting the onus on the individual. Rodmell and Watts (1986) describe health education as ineffective and unethical in 'blaming the victims' for their problems. Strategies that focus exclusively on individuals ignore the consistent findings that there is a clear gradient of declining health and higher morbidity with declining social class status (Whitehead 1992). It is of note that a change of government has resulted in the publication of a Green Paper, Our Healthier Nation (DoH 1998), which attempts to indicate a need for structural change as well as health education.

In a book designed to give practical advice on health promotion issues, Ewles and Simnett (1998) use the term 'information giving' to describe an approach which aims to give knowledge and ensure understanding of health issues to allow informed decisions. However, it can be argued that it is unlikely that any information giving process can be entirely free from the givers beliefs and values and Fahrenfort (1987) notes that the need for patient information may come from two different perspectives. Either a patient centred one in which autonomy is the key or, a medically centred one which aims to gain compliance. The notion of compliance implies a dependant lay person and a dominant professional and fits with Parson's (1951) view of the role of the patient as passive and cooperative.

Health education information, then, is a term embracing a range of possible activities. It emphasises individual responsibility for health but nevertheless it can be argued that individuals have to have accurate information so that they can make informed decisions about their health behaviour. Health education will not necessarily result in people changing their behaviour but there is a convincing argument that without information patients are unable to make informed decisions about their health. In the context of this study 'health education information' implies information given to patients about their illness, treatment, prognosis and guidance for recovery.

Patient's Preferences

One of the difficulties in the provision of patient information is assessing how much patients actually want to know about their condition. It is impossible to generalise and there is likely to be a wide variation between individuals. In addition to the question of the amount of information required is the issue of what type of information patients require.

Wallace (1985) studied women undergoing gynaecological surgery and found that they wanted additional information to that given to them in preparation for surgery. The type of information they required was reported to be procedural rather than information for coping or reassurance. The women in the sample were all undergoing surgery for sterilisation or infertility and this may set them apart from women undergoing surgery for ill health.

However, this desire for procedural information is also reflected in other studies (Porter 1990, Weijts *et al* 1993). Porter (1990) found women undergoing gynaecological surgery in Aberdeen demonstrated more concern about issues such as how long they would be in hospital, than issues of diagnosis and treatment. Women who were told they were to undergo hysterectomy rarely questioned their diagnosis or treatment. No information is provided about the social background of these women. Weijts *et al* (1993) in a Dutch study of gynaecological consultations indicated that women only asked questions about procedural aspects of care and not 'what' and 'why' questions about their treatment. Two

thirds of this sample of women were reported to be working class.

Bubela *et al* (1990) studied a large sample of medical and surgical patients in one hospital in the USA and found that informational needs were influenced by gender and level of education. Females were reported as asking more questions than males and had more informational needs at the time of discharge. Participants who had not attended further education desired more information than those who had. The type of information they demanded was not specific.

In a comprehensive review of the literature Biesecker (1990) reported that empirical evidence, largely American literature, indicated that patients want information from their physicians but are often hesitant to ask. He also reported, however, that some patients actively chose to remain passive. Porter (1990) in her UK study also indicated that the gynaecological patients interviewed rarely expressed dissatisfaction with their consultations with the doctor and she commented that it was rare for a woman to express annoyance even with the most untoward event.

Mitchell (1997), in an investigation of women undergoing gynaecological day surgery, compared their health locus of control with their need for preparatory information. Though he found no correlation between health locus of control and level of selected preparatory information he suggests that the diversity of scores within the patient questionnaire clearly demonstrates the need for differing levels of preparatory information to take account of various coping styles.

It can be concluded that there is a wide variation in patients' desires for health education information both in amount and the types of information required. Procedural information seems to rate highly in studies of women undergoing gynaecological surgery (Wallace 1985, Porter 1990, Weijts *et al* 1993). This may reflect the nature of women's lives where not only does paid employment have to be considered but also the organisation of family responsibilities and child care, and often, the role of an informal carer.

However, these studies using observation and structured questionnaires fail to address women's feelings about the information they receive. What are their attitudes and expectations? Can we treat women as a homogeneous group or are there individual differences in the amount and type of information they desire? Mitchell's (1997) study indicates that a diversity of information is required but fails to explore the meaning of that information for the different women concerned.

Who Should Provide Information

Opinions as to who should provide health education information in hospitals vary. Research suggests that nurses themselves perceive that health education is an important part of their role (Close 1988, McBride 1994, Cantrell 1997). McBride (1994), in a study of two hospitals in the UK, found that 95% of the 225 nurses interviewed felt that they should be the providers of health education. The involvement of nurses in health education was also supported by the majority of other health professionals included in the study. Close (1988) in a review of the literature, also reported that health professionals largely agreed that nurses should play a substantial part in health education. They indicated a view that nurses had more opportunity to provide this education because they spent more time with patients compared with other members of the health care team.

Tilley *et al* (1987) points to an incongruence between nurse's and patient's perceptions of the nurse's role in health education. In a small study of two teaching hospitals in Canada she found that though patients acknowledge nurses as sources of information they actually prefer physicians to teach them, though the expectations of patients who are directly purchasing health care rather than using a tax based health system may have something to do with these findings. However, Wallace (1985), in a study of patients undergoing minor gynaecological surgery in the UK, also found that patients preferred information to be provided by the surgeon. In Finland, Suominen *et al* (1994) reported that patients expect information from both doctors and nurses.

There is also little agreement between patients and health professionals as to who actually teaches patients. Tilley *et al* (1987) demonstrated that while the nurses most frequently identified nurses as delivering health information the patients frequently chose physicians. Souminen *et al* (1994) in agreement found that neither patients or nurses were clear about the nurse's role in health education.

Past research indicates that although nurses and other health professionals identify nurses as playing a substantial part in the provision of health education information to patients in hospital (McBride, Close 1988), the picture is not as clear from the perspective of the patient. Patients both seem to prefer information to be provided by the doctor (Tilley *et al* 1987, Wallace 1985) and they are unclear about the nurse's role in terms of providing information (Souminen *et al* 1994). However, none of these studies looked at individual differences and it must be questioned whether all women want their information from doctors or whether there are individual differences.

Language

Differences between social and educational backgrounds between health professionals and the patients they communicate with may present barriers. In a complex study of language Bernstein (1971) identified a variation in the way language is used, interpreted and understood according to social background.

Bernstein identified two linguistic codes; the restricted code and the elaborated code. The restricted code is very simple involving a limited range of alternatives and is descriptive and narrative. The elaborated code is complex, does not rely on common understanding of meanings and is analytical. Bernstein identified that the restricted code was used by working class families while the elaborated code was used by the middle classes. He postulated that the use of different codes made it difficult for working class children to communicate with middle class teachers.

Although Bernstein's work was primarily with children it is possible there is a continuation of this effect into adulthood. This has implications for health professionals and their patients. Health professionals are drawn largely from the middle classes. Although there are some doctors from working class backgrounds, Allen (cited in Bagot, 1998, p44) provides evidence that the majority are drawn from the upper middle classes. In a small survey of nurses in one health authority Ling (1989) found that the majority of nurses originate from middle class backgrounds. Communication between health professionals and their working class patients may thus be hindered.

Accent and language are also cues for identifying dominance and deference in relationships when people interact. The dominant speech style is loud and confident with more talk and more interruptions whilst the deferential style is the opposite, quieter with less talk and less interruptions (Argyle 1994). Dominance can be generated by hierarchies of power in the situation, where one is doctor, nurse or patient, but the status difference will be increased where speech codes differ. Working class women using either a submissive or deferential speech style will be less able to exert power in their relationship with health professionals than middle class women, who adopt a more dominant style.

A further issue in the use of language is the adoption of different registers by health professionals and patients in the hospital setting. Bourhis *et al* (1989) investigated the use of 'everyday language' and 'medical language'. Doctors and nurses speak both everyday language and medical language whereas patients converse in everyday language and are typically unfamiliar with much of the medical language. Bourhis *et al* (1989) reported that the three groups studied, patients, nurses and doctors, felt that the use of medical language led to communication difficulties. But, though doctor's self reports indicated that they converged to everyday language when talking to patients, this was not corroborated by patients and nurses. Some patients reported making an effort to use medical language but all groups agreed that nurses acted as communication brokers for the everyday language of the patient and the medical language of the doctors.

Hadlow and Pitts (1991), in a study of the understanding of common health terms by

doctors, nurses and patients, demonstrated clear differences in understanding. The level of understanding was highest for doctors and lowest for patients. Terms, such as depression, were shown to have both a clinical and a lay meaning which led to misunderstanding.

Smith (1997), in a study of older patients and communication, noted that dissatisfaction was expressed when staff used terms that they were unable to understand.

Language, no doubt, plays an important part in the information giving process.

Communication of information can be hindered by the different social backgrounds of the patient and health professionals. Accent and language will also play a part in defining power relationships when patients interact with doctors and nurses. The use of medical jargon further affects the effectiveness of communication and can lead to both misunderstanding and patient dissatisfaction (Bourhis *et al* 1989, Hadlow and Pitts 1991, Smith 1997).

Influence of Patient Characteristics

The amount of information that patients receive may be dependant upon their socio-demographic characteristics or their attitude or manner. Most studies, however, focus on the doctor patient relationship and little has been written in respect of the patient's communication with other health professionals.

In Tuckett *et al's* (1985) study of 1,470 general practice consultations, middle class patients were found to have longer consultations and receive fuller explanations than working class patients. Forty-five per cent of middle class patients sought clarification from the doctor while only twenty seven per cent of working class patients did so. In a review of the literature Beisecker (1990) also notes that research on socio-demographic factors indicates that patients with high income and greater education tend to ask more questions and receive more information from doctors. Street (1991) provides further evidence that doctors volunteer more information to more educated patients.

Beisecker (1990) reports that the literature indicates that younger patients receive more information from doctors than older ones. Street (1991), in a study in the USA, found there was a modest trend for the younger patients to receive more information. However, Street's (1991) main findings were that doctors informativeness was strongly related to the frequency with which patients asked questions. Results of the study suggest that the amount of information doctors give to the patient is influenced by the patient's communication style, however, it must be questioned whether this response is more prominent in the USA where patients pay directly for treatment.

In an observational study of women in labour in one hospital in the UK, Kirkham (1989) reported that women of higher social class gained more information from midwives both in answer to questions and as unrequested information. The information that midwives provided to women in labour could, to a large extent, be seen as a response to the social class of the woman and the tactics used by her and her partner to put staff at ease. When interviewed following a period of observation midwives indicated that they provided more information to women who they assessed to be more intelligent. Working class women, who were considered to be less intelligent, were not seen to be in need of detailed information.

Studies of doctors and their patients (Tuckett *et al* 1985, Street 1991) indicate that a patient's social background affects the information they receive in consultations with doctors. This appears to be partly influenced by the patient's ability to ask questions and extract information and partly due to the doctor's perceptions of the patient. Kirkham (1989) has demonstrated similar findings in a study of midwives, but there is a need for more research on the information giving process between patients and nurses.

Patient Satisfaction

In a large national study, Bruster *et al* (1994) surveyed patients opinions of their experiences in hospital focussing on what happened rather than upon their satisfaction.

Much of the survey dealt with communication between health service staff and patients. They reported that patients were not given important information about the hospital, its routine and their condition and treatment. There was particular dissatisfaction with information about tests and surgery and the lack of opportunity to discuss these with staff. Patients who were worried about leaving hospital reported that they felt they lacked help from hospital staff. Many patients were discharged without having been given information about returning home and how to help their recovery.

In contrast Cortis and Lacey (1996) reported satisfaction with the level of information received by patients discharged from one hospital's general wards over a year. This smaller study measured satisfaction using a fixed choice questionnaire as opposed to what actually happened, as in Bruster *et al's* (1994) study. Avis *et al* (1997) suggest that asking patients about overall satisfaction often results in positive replies, whereas, specific questions about actual processes of care can elicit critical responses.

Cortis and Lacey (1996) note that patients qualitative comments refer to sympathy for overworked staff. Smith (1997), in a study of older people's satisfaction with information, also reported that their responses are noted for their gratitude and reluctance to criticize health professionals. Smith (1997) used open ended questions to avoid compliant and positive answers. They coded 41% of their sample as dissatisfied with the information they received about their illness.

It seems that whilst patients attempt to demonstrate loyalty to health service staff (Cortis and Lacey 1996, Smith 1997) there is overall dissatisfaction nationally with the information giving process in hospitals. While the use of fixed choice questionnaires resulted in a positive response in one particular hospital (Cortis and Lacey 1996) the most recent large national study (Bruster *et al* 1994) indicates that standards of the Patients Charter (1991) pertaining to information giving are not met. Patients are not satisfied with the information they receive about their illness and its treatment.

Gynaecology Patient's Satisfaction with Information

Studies of women undergoing hysterectomy have demonstrated a lack of satisfaction with the information they received (Webb and Wilson-Barnett 1983, Webb 1986, Bernhard 1992, Haas and Purezt 1992).

Webb and Wilson-Barnett (1983), in their study of patients recovering from hysterectomy, found that lack of information featured highly when women talked about their experiences. A sizeable minority had not received an explanation of the operation they were to undergo. They reported that the women did not feel prepared and the information provided for recovery was considered vague and unspecific and restricted to one or two items, whereas, the women wanted realistic concrete expectations.

In a later study looking at professional and lay support for patients undergoing hysterectomy Webb (1986) found again that patients reported lack of information as a problem. In interviews following their surgery thirty-seven out of forty-eight women complained that hospital staff had not provided sufficient information regarding the operation, its effects and the convalescent period. Neither of these studies made reference to socio-demographic differences though Webb and Wilson-Barnett (1983) suggested that further research should include the varying needs of different client groups.

In a longitudinal study of sixty-three women who had undergone hysterectomy, Bernhard (1992) found that the women reported that the main reason for mixed feelings about hysterectomy was the conflicting information they received from the people they talked to. Bernhard's (1992) study took place in the USA and the women were all drawn from the lower socio-economic classes. She makes little reference to the role of health professionals in terms of information giving, but reports that the most frequently consulted persons for health advice were the women's mothers. Haas and Puretz (1992), also in the USA, further demonstrated women's dissatisfaction with the information they received. A third of the sample of 128 women who had attended various medical centres reported a lack of information with regard to the surgical procedure and recovery at home.

Lack and Holloway (1992), in a British study, looked specifically at the information needs of women who had their ovaries removed at the time of hysterectomy. In a small study using unstructured interviews they found that patients reported a lack of knowledge. The amount of information given to the women by their doctors varied though the women indicated that they expected the doctors to provide information unasked. Some of the women felt dissatisfied about their lack of choice and their uncertainty about side effects. The ages of these women were 32 to 56 years but no further socio-demographic information was provided.

Studies which have looked at the provision of information in the private sector in Britain (Chapple 1995, Coulter *et al* 1995) present quite a different picture. Chapple (1995) used a quota sample, in which half the women were well educated and half had left school with no more than the statutory minimum education, to explore the experiences of women that had undergone hysterectomy in both the NHS and the private sector. Almost all the women seen in outpatient clinics in NHS hospitals felt that they were not given enough information and they were rushed while all the private patients were positive about their dialogue with their doctors and felt they had plenty of time for questions. The experience of private patients was not affected by their social class or educational background.

Coulter *et al* (1995) also found that private patients reported more positive experiences. In a large study of women who were suffering from menorrhagia it was found that patients who went to private clinics were more likely to report active participation in decisions about their care. This difference was significant even after adjustment for age and educational status. Overall levels of satisfaction were high in both groups though it is noted that questionnaires were used to collect data and as Avis *et al* (1997) point, out asking patients about overall satisfaction tends to lead to positive replies.

Research both in Britain and the USA indicates that women are dissatisfied with the information they receive from health professionals when undergoing hysterectomy (Webb and Wilson Barnett 1983, Webb 1986, Bernhard 1992). None of the studies, to date, have made comparisons of women's experiences according to socio-demographic variables.

The private sector in Britain appears to be the exception, where women report a positive experience of receiving information (Chapple 1995, Coulter *et al* 1995). These studies, however, focus on the relationship between the patient and the gynaecologist and little reference is made to the role of the nurse in providing health education information.

Conclusion

Evidence suggests that patients do not receive the health education information they require when in hospital (Bruster *et al* 1994, Smith 1997, Webb and Wilson Barnett 1983, Webb 1986, Bernhard 1992). There is a wide variation in patients desire for information both in terms of quantity and type with some patients demonstrating a preference for procedural information.

Nurses and other health professionals identify nurses as the appropriate members of health care staff to deliver health education information. However, the picture is less clear from the patients point of view. They demonstrate a preference for information from the doctor and are less clear of the role of the nurse in providing information.

Poor communication can, in part, be seen as due to difficulties with language. Bernstein's (1971) work indicates the possible barriers to communication between middle and working class individuals. Accent and language may also affect power relationships between women and the health professionals they talk to. Later studies (Bourhis *et al* 1989) on the use of medical language indicate that communication breaks down between doctors and their patients because of the use of medical language by doctors. Nurses act, to some extent, as communication brokers between doctors and patients.

Socio-demographic variables affect the level of information giving from doctor to patient. Research (Tuckett *et al* 1985, Street 1991) indicates that doctors give less time and less explanation to working class patients than to middle class patients. Observation (Tuckett *et al* 1985) has also demonstrated that middle class patients ask more questions and demand

more explanations than their working class counterparts.

Women undergoing hysterectomy consistently indicate that the lack of information they receive regarding their operation and their recovery is the worst aspect of their care (Webb 1986, Bernhard 1992, Haas & Poretz 1992). Although studies of patients and their doctors indicate that the patient's class position plays a part in determining the information they receive this has not been explored specifically in studies of women. There is also little evidence of research that looks at the information giving process between nurses and their patients.

THE SOCIAL CONTEXT OF THE DATA

Introduction

Data collection for this study took place between 1996 and 1997. The women I interviewed had spent approximately five days in hospital undergoing surgery and had also attended the out-patient clinic. Their experience of receiving health care did not take place in a vacuum but was influenced by the culture of health care in the mid nineties. It is, therefore, useful to address the events and structures that may have influenced their experience.

Our knowledge and beliefs are derived from society and our reality is socially constructed (Stacey 1992). The world is not perceived neutrally but what we see is shaped by our social values. This study is an exploration of how the values and belief systems of women influenced their experience of gaining information about their own health and health care when they were undergoing elective surgery. Structural forces will have shaped their ideas and expectations of health care services and so it is pertinent to examine the influences on health service policy in the nineties, the roles of health professionals and the part that the media play in informing the public's expectations of health issues.

Health Policy

Through the eighties and early nineties the new right thinking of the conservative government promoted ideas of individualism and worked to reduce what they called dependance on the welfare state. They applied market principles to the welfare services and to a lesser extent the National Health Service (NHS). They promoted family values and

encouraged families to care for individual family members with a view to decreasing the role of the state.

In the late eighties the Thatcher government produced a White Paper - 'Working for Patients' (Department of Health 1989b) that spelt out the most far reaching changes to the NHS. Despite a campaign by the British Medical Association (BMA) and other health service unions the main elements of 'Working for Patients' became law in 1990. An internal market was developed within the framework of the NHS and purchasers and providers were split. The main purchasers for hospital care being health authorities. General Practitioners (GPs) became second line purchasers and were encouraged to become fund holders from which they could buy non-emergency hospital care for their patients. The hospitals and community services were encouraged to opt out of health authority control and become self-governing NHS Trusts. The internal market began operation in April 1991 and by 1995 over 95% of hospital and community health services were operated by NHS trusts (Mays 1997).

The inception of the internal market may have affected the way in which services were delivered to the women in this study. If they had fund-holding GPs then there should have been some element of choice as to the hospital from which their surgery was purchased. However, Pollitt (1989) suggests that the patient does little more than make a choice of GP, and it is then the GP who does most of the choosing

Perhaps a more significant factor affecting women's experience of using the health service has been the emergence of consumerism as an integral part of health service rhetoric. Participants of this study were undergoing their surgery at a time when the health policy was referring to active consumers rather than grateful patients.

In 1991 the government produced the Patients Charter (DOH 1991) which set out ten national rights and service standards that patients could expect from the NHS. It did not directly empower patients but highlighted the patient's perspective and indicated some minimum requirements the patient could expect. It is significant to this study to note that

the Charter states that existing rights include: “to be given clear explanation of any proposed treatment, including risks and alternatives”

So by the mid-nineties the language of consumerism had found a place in the NHS. Ideologies of patient choice, empowerment and autonomy were infiltrating health service policy (Jensen and Mooney 1990). However, it is questioned as to what extent the principles of consumerism can be applied in the health care context. Consumer theorists usually identify five dimensions to empower users: access, choice, information, redress and representation (Pollitt 1989). Oakley (1993) argues that consumers of health care do not really have the opportunity to choose the care they want. In a tax-based health care system users do not control where their money is spent and consumer choice is only possible with direct consumer payment. Unlike the free market from which the concept of the consumer was drawn, the health service has a monopoly and there are few options to which users can turn. Only those who can afford to buy private health care can take their custom elsewhere.

While free market consumerism is not possible in a state run service, a focus on consumerism may yield some power for patients. Hayden (1990) suggests that focussing on the consumer's experiences helps create a service more oriented to their needs. Though Avis (1992) warns that this can be an attempt to please people superficially rather than an allocation of rights.

Working for Patients (DoH 1989b) and the Patients Charter (DoH 1991), then, represented a package of changes which have influenced the culture of the health service accessed by the women interviewed in the mid nineties. The rhetoric suggests users of the NHS were encouraged to be active consumers of health care in a system that was market oriented and offered choice and empowerment.

Health Promotion

The conservative government produced a further paper on health policy in 1991 setting out

a health strategy for England with the goal of improving the health of the nation. The White Paper, Health of the Nation (DoH 1992) identified five clear areas for action based on classic epidemiological targets. The stated goals were to 'add years to life' and 'life to years' incorporating increased life expectancy and increased quality of life. The chosen targets reflected a medical rather than a social perspective and were related to disease rather than the overall promotion of health.

The dominant ideology of the paper was the preventative model of health education. Through the eighties and early nineties the theme of individual responsibility for health was emphasised by the government. The preventative model of health education is closely related to the medical model and as such adopts a reductionist approach with health identified as the absence of disease. The paper centred on 'victim blaming' and Tones and Tilford (1994) note that though reference was made to broader social determinants of health more specific reference was made to individual behaviours. The Health of the Nation paper reflected the individualistic enterprise culture of the eighties in which the individual is held responsible for their own health in terms of lifestyle decisions made.

The paper identified hospitals as key settings for health promotion. It stated that hospital, as well as providing treatment and care, could offer more general opportunities for health promotion. Health education was also increasingly recognised as a legitimate and valid part of nursing. The Department of Health, Strategy for Nursing (1989) recommended that health education and health promotion should be recognised as part of health care. McBride (1994) in a study of hospital nurse's attitudes to health promotion reported that health care professionals were keen to integrate health promotion into their practice.

Women in this study were undergoing their surgery at a time when hospitals were identified as centres for the activity of health promotion. Government initiatives emphasised individual responsibility for health with an expectation that individuals should make the lifestyle changes necessary to prevent disease, an approach which was deemed ideologically sound in an individualistic enterprise culture.

Health Professionals

Women who participated in this study attended an out-patient department for their consultation with the gynaecologist and spent, on average, five days in hospital. Admission to hospital forms a major event in people's lives and most people feel uneasy and anxious about it. When patients enter the hospital they enter a medical world in which they must conform to rules and routines that are unfamiliar to them. They lose their status, their bodies are subject to total control and the boundaries of the private and public spheres are dissolved (Lupton 1994).

Hospitals like any other large organisations are subject to constant change. They were originally founded as institutions to deal with the poor who were sick and have developed into major sites of clinical practice and research. As well as the provision of patient care hospitals also serve as centres for educating doctors, nurses and other health workers. Hospital care in contemporary Britain is provided by health care workers who are organised into professions. Women undergoing hysterectomy would have been looked after by nurses, doctors, and paramedics working alongside each other in what is now described as a multi-professional team.

The multi-professional team is largely drawn from the middle classes. Traditionally doctors have been drawn from the upper and middle classes and although there has been some change, as discussed in the last chapter, they remain predominantly middle class. Nurses, though at one time mostly working class, are now also largely middle class. The increased emphasis on education and academic qualification indicates that this will continue.

Nurses and doctors working within the NHS have undergone role changes in the last decade which may have repercussions for the care women experienced. The status of nursing has risen through registration, education and research. Since the beginning of the nineties nurse education has moved away from the narrow apprenticeship and training model to a higher education programme in which students are granted full student status, and, are awarded with a diploma of higher education as well as registration. The curriculum

for nurse education was traditionally built around the medical model but now includes the social sciences with an emphasis on holism. In a small ethnographic study of gynaecological nursing McQueen (1997) described how nurses showed an appreciation of the need to care for patients within their particular social context.

Nurses are expected to deliver individualised patient care rather than adopting a task oriented approach as in the past. Care is centred on the patient's needs, views and preferences with an aim of acknowledging the individual's unique experience (Wilson-Barnett 1994). A patient centred approach advocated in recent years has meant that patients should be treated as partners rather than passive recipients of care (Lupton 1995). The emergence of primary nursing has meant that nurses are given responsibility for managing care of a group of patients. The Department of Health Nursing Division (1989) stated that every patient should have a named nurse identified as responsible for his/her care and this was re-inforced in the Patients Charter (1991).

Nurses along with other para-medics are attempting to become autonomous practitioners with direct responsibility for patient care. This is in opposition to the traditional control that was exerted by doctors and increased emphasis is given to a collaborative multi-professional approach to care. But caring remains the important part of the nurse's role in practice and Oakley (1993) argues that caring is not viewed as important work. Caring is seen as 'women's work' which devalues it while male dominated medicine is associated with curing which is about activity and achievement. Doctors cure while nurses care and the power and authority possessed by medical staff is an important part of the relationship between doctors and nurses (May 1992b). While nurses are given primary responsibility for the care of patients they remain subject to the imposition of medical authority, which reduces their potential to exercise professional autonomy.

Women's relationship with nurses is more complex than their relationship with their doctors. Nurses are expected to know their patients as individuals rather than as a set of symptoms (May 1992b). It is also of significance that most nurses are female and still the majority of doctors are male which will have some bearing on the relationship between

gynaecology patients and the health professionals they talk to. The gynaecological nurses in McQueen's (1997) study expressed empathy with their patients and indicated that they had a belief that being women themselves helped them to understand some of the feelings and experiences of their patients.

In contrast to nurses, doctors have traditionally been valued for their 'scientific' knowledge and their approach to patients has been given less significance. Lupton (1994) noted that if a doctor is highly valued for his or her technical expertise then it is considered acceptable if he or she fails to demonstrate empathy. However, Boseley (1998) points out that the medical profession is changing and doctors have a greater openness with patients. Communication with patients is now part of the curriculum in medical schools, and students are taught with a focus on real cases rather than in the traditional theoretical manner.

The Media

The media play some part in shaping women's expectations of health and health care. Women's magazines are major sources of information about women's complaints and frequently inform the public of the new innovations and treatments. Television also has a role in informing the public of health matters both in the more serious documentaries and in the numerous viewer participation shows that have emerged in recent years.

The Internet is a further source of health information. It is estimated that world-wide six hundred new pages devoted to health issues appear on the Internet each day (Lilley 1998). Patients are now able to arrive at their doctors with the latest research and developments relating to their condition. It has opened access to information that in the past was only available to health professionals.

Conclusion

The women in this study, then, underwent their surgery in an NHS that was influenced by the health policy of the late eighties introduced by the then Tory Government. The service had adopted a market orientation and competition was the buzz word for increasing efficiency. The consumer approach was installed and patients were encouraged, in theory at least, to think of themselves as consumers of the service rather than as patients. The Patients Charter set out rights and guarantees of what they should expect from the service and this included the right to full explanation of treatment and its risks.

Nurses were more highly educated than ever before and individualised care, primary nursing and the named nurse all stressed the value of involving patients in a partnership in care. Women entering hospital were nursed by a workforce that was fighting for professional autonomy identifying themselves as patient advocates rather than doctor's handmaidens. The role of doctors was also undergoing some change. Young doctors were publicly acknowledging the need to listen to patients and emphasis was given to a patient focus in medical training.

A powerful mass media allowed the public to be better informed of treatments available than ever before. Added to that the appearance of the world wide web provided health information and information on research to the general population that had previously only been available to health professionals. Women were able, if they had the resources, to gain some information from sources other than health professionals.

So has consumerist rhetoric affected the relationship between doctors and nurses and their patients? Has it given patients even greater expectations of empowerment and autonomy or, more significantly, has it changed the attitudes of some and not others? Is it that middle class patients who have greater access to communication networks, and are from a similar class background to health professionals, have different expectations to their working class counterparts?

SOCIAL CLASS

Introduction

The topic of class is well known in British society, everyone has an idea of what class is and it is a topic of both entertainment and derision. In the late nineteen eighties the then Prime Minister, John Major, talked of Britain being a classless society, but studies revealing inequalities appear to refute this. The persistence of wealth and power at the top and growing poverty at the bottom suggest that class divisions persist (Hout *et al* 1996). Those in less advantaged socio-economic circumstances suffer more ill health and have higher mortality rates than those in more advantaged positions (Black 1980, Whitehead 1992, Acheson 1998). Other aspects of inequality such as education and career prospects show us that those who are disadvantaged in one area of life are likely also to be disadvantaged in others (Reid 1989).

The term social stratification refers to this kind of socially structured inequality and the concept of class describes the form of stratification in contemporary Britain. Within the study of sociology class is a central theoretical concept. It may be described in an abstract manner either as a social force on historical development as in the work of Marx, or, it may be approached as a grouping of positions or places as in empirical investigations. Finding an adequate measure for social class, however, is problematic. In this study where women are the subject, it poses an even greater problem because of their absence in both theoretical and empirical studies of stratification.

In this chapter theories of class and their influence on empirical classification will be discussed. The problem of classifying women will be addressed and schemes that have attempted to address the 'woman problem' will be assessed with the identification of a *schema* for use in this

study.

Theories of Class

The concept of class is complex and has been the subject of much discussion and sociological debate. The theoretical contributions of Marx (1818-1883) and Weber (1864-1920) have had a major impact on class analysis. Marx was a political activist whose aim was to provide an analysis of capitalist society. He saw class as a process, a force acting through history. His account of class focussed on the economic and antagonistic relationship between the owners of the materials of production, the bourgeoisie and the proletariat who were forced to sell their labour to the bourgeoisie in order to survive.

Weber, in contrast to Marx, identified classes in terms of their specific possessions. According to Weber class divisions derive from economic differences which have little to do directly with property. He saw goods, skills and qualifications as the basis for class identification. Weber believed that groups most likely to act together would be those based on status, knowledge and skills, in contrast to the purely economic basis of Marx's class situation.

Since the analyses of Marx and Weber issues of class have been widely debated and writers have addressed the contentions between the two. Those working in the Marxian tradition have further developed Marx's ideas whilst Weberians' have elaborated on the concepts devised by Weber. Contemporary accounts that have influenced empirical work research are those of Wright (1985) and Goldthorpe (1983). Wright's work has involved a revision of Marx's model of class whereas Goldthorpe's contribution is based on the work of Weber. The two represent major theoretical traditions of social class analysis (Edgell 1993).

Women and Class Theory

Class theory has historically treated women as marginal and abstract class theory has been

accused of being blind to gender issues (Crompton 1989). Theories of class have been seen as being about explaining inequalities and thus have concentrated on economic and occupational structure.

Marxists argue that gender is not an issue because capital is indifferent to the labour that it exploits. Marxist analysis views the capitalist mode of production as a system in which the bourgeoisie exploit the proletariat. No need is seen to acknowledge gender as part of the inequalities debate because class is the major form of inequality and women are more divided by class inequality than by gender inequalities.

Wright's neo-Marxist scheme was developed directly from Marx's theory and locates individuals in classes according to their relationship to property. Wright (1985) based his scheme on an occupational structure based on the division of labour and like Marx ignored gender. However, the most universal form of division of labour is that of the sexual division (Crompton 1989). Although women's occupations have changed to some extent over the last century in Britain they are still found clustered within certain areas of work. Women still predominate in personal service and clerical occupations and outnumber men by four to one in health and two to one in education sectors (Central Statistical Office 1995). Women still predominate in occupations that reflect the traditional role of the woman.

Marxist feminists challenge the conventional Marxist view of class and believe women's role as performers of domestic duties within the family needs to be understood. Whilst radical feminists argue that women's oppression is the primary cause and should be separated from class Marxist feminists argue that gender and class have a mutual influence. Delphy (1984) believes that women are a class exploited by gender and, thus, the main differentiation should be gender. In contrast, Pollert (1996) claims that although class and gender may be conceptually different, in social processes they are inseparable.

Weber, like Marx, largely ignored gender in his theories of class. As far as Weberian approaches are concerned if female 'life chances' are not market determined then it is logical to see them outside of the bounds of class theory (Crompton and Mann 1986).

Goldthorpe's class scheme emerged from the theory of Weber. In this scheme the division of labour is made up of basic employment relationships and by "varying employment functions and conditions of employment which differentiate categories of employee" (Goldthorpe 1983 p467). Goldthorpe uses the household as a unit of analysis and identifies the male as the head of the family for stratification purposes. He claims that this has been arrived at through two quite different theoretical routes which will be discussed.

Parsons (1951) has had a dominant influence on stratification in North American sociology. This functionalist theory has used the family as a unit of analysis for two main reasons. Firstly that if husband and wife were brought into competition for status through their position in the labour market it would form a threat to the family and therefore to the stability of society. However, he does not make clear why the male should always be the individual coded for stratification. Secondly, if individuals within the family were to be classified in different positions and therefore allocated different status, it would be difficult to place them in the community alongside other families. Social stratification is thus seen in terms of status and is, of course, a determinedly functional view.

In trying to understand stratification in terms of class rather than status Goldthorpe (1983) refers to the historical division of labour. He describes this as constituted by the differentiation between employers, self-employed and employees and, structured by varying employment functions and conditions of employment. Goldthorpe (1983) believes that it is not the aim of class analysis to account for the structure of class positions or the degree of class formation within them. He further believes that class theorists would agree with the functionalist that the family as a whole should take their position from the family head, the male, as it is he who has the greatest participation in the labour market. In Goldthorpe's (1983) view, women's patterns of employment can be largely explained by the occupational class of their husbands. He perceives that women have less involvement in the workforce than men and contemporary marriages are largely homogenous in respect to class.

There is major criticism of this theory of class which has treated half the population as marginal, where women have not been recognised even when they are members of the wage

earning population. (Allen 1982). Abbott and Sapsford (1986) believe that ignoring women in class coding is a convenience and also indicates that women's experiences and social standing are not their own in the sense that men's are. Goldthorpe (1983), however, states that while class theorists treat the family as a unit of stratification they do recognise major sexual inequalities and acknowledge the subordinate position of women in society in general. He goes on to argue that women's role in the family is determined by the socio-economic position of the family. Women's life chances and employment are therefore determined by the occupation of her husband. Stanworth (1984) in a response to Goldthorpe, claims that women's subordinate class positions are an expression of men's dominance over women through the processes of class formation and class action. She does not accept Goldthorpe's view that it is the dominance of husbands over wives.

The idea that women derive their own status from that of their husband has been challenged. Allen (1982) suggests that when a woman marries she does not automatically take on the educational and occupational achievements of her husband, nor does she acquire his socially and politically powerful background. A woman's real class position maybe more closely linked to her own educational background and achievements.

Heath and Britten (1984) demonstrate that although there is a strong association between women's careers and their husband's class, women's own educational and vocational qualifications play a very important part. Using a large randomised sample Heath and Britten's (1984) analysis indicated that a woman's own educational and occupational qualifications are more important than the class position of her husband in influencing her career path. Stanworth (1984) suggests that the conditioning works both ways and that a wife has effect on her husband's employment as well as vice versa.

The intermittent nature of women's work has been a further cause for Goldthorpe (1983) to assert that the pattern of employment of married women is class conditioned rather than class determined. Whilst Heath and Britten (1984) do not deny the intermittent nature of some women's employment and the influence that class has on this, they do believe that to a greater extent a woman's own qualifications and work history influence her own employment. They

see her potential for participation in the labour market as more significant than her current position. Heath and Britten (1984) claim that their research data indicates that women have a strong commitment to particular types of work which would serve to form distinctive patterns of class behaviour. Walby (1986) claims that Goldthorpe's own evidence shows only a minority of married women take more than one break from paid employment and considers that it is not appropriate to refer to this as intermittent employment.

Goldthorpe's (1983) third major argument is that contemporary marriages are largely homogenous in reference to class, he claims that few working class or intermediate class men marry women of a superior class position. Goldthorpe (1983) also argues that for manual men who marry women in routine non-manual occupations the superiority is more apparent than real. By this he means that women in routine non-manual jobs tend to hold positions where market and work conditions would match those of their husband's in manual occupations. While Stanworth (1984) accepts the latter part of this argument she believes it cannot bear out the view that most married women are adequately represented by their husbands occupational class. She believes if women non-manual workers are re-categorised as manual it merely changes which families are cross class. Walby (1986) raises the issue that Stanworth does not consider the class position of full time housewives and goes on to argue that husbands and housewives form two separate classes.

Empirical Classification Schemes

Moving on from class theory to empirical classification systems occupation is still used as the measure of social and economic circumstances. The use of occupation assumes similar lifestyles and orientation to social action will be experienced by those in similar work positions (Mills 1994). Using class in empirical work means moving away from class theories to maps of class structure. The most commonly used indicator of class categories in empirical work is the Registrar Generals classification. The Office of Population and Census (1980) claim that the occupational groups in each of the categories represent, as far as possible, people with similar levels of occupational skill. It divides the population into five social classes according

to their skill level and general standing in the community. It is a descriptive scheme devised for social policy purposes rather than a contribution to sociological debate (Crompton 1994). Drudy (1991) proposes pragmatic reasons for its continued use, claiming it is easy to use, easy to interpret, and because of its extensive use allows researchers to compare findings with official figures.

Still in this type of class *schema* the ideology of the family being a unit where all females and minor males dependent upon the head of the household (the male) persists. Men are generally assigned to a group according to their occupation whilst women and children are ascribed their social class through their relationship with the man of the household. Thus in assigning individuals to a social class their sex and position in the household are often crucial (Graham 1984).

Ignoring women in classification systems means that males have their class position ascribed by their own occupation, whilst other women are given a class position according to the occupation of the person they live with (Abbott and Sapsford 1987). Barker and Roberts (1990) claim it is inconsistent to classify a woman by her own occupation until the day she marries and then classify her by the occupation of her husband. McRae's (1986) study of cross class families indicated that living together does not necessarily result in shared social imagery or shared attitudes to class action and Allen (1982) believes that a woman's status and class fate is more likely to be linked to their own class background than that of their husband's. Oakley (1974) defends the use of the Registrar General's head of household classification in her study of housework. She claimed it enabled comparisons to be made with other studies. Roberts (1981) comments that this puts reliability and replicability above the criteria for validity.

Joint Classification

An alternative offered is that of a joint classification (Britten and Heath 1984). This would be based on the employment situation of both husband and wife. Goldthorpe (1983), however,

has argued against this, contesting that the occupation of the wife may be merely spurious and therefore of no real significance in the classification of the household. Where material on wives has been included the result is modified but not radically altered (Goldthorpe *et al* 1988). Goldthorpe (1983) suggests that if the approach is trying to achieve a measure of socio-economic status then it would be better to use a measure specifically devised for this.

Individualistic Approach

A further alternative is that of an individualistic approach, using women's own occupation when ascribing class position. Allen (1982) argues that women are involved in the system of class relations in their own right and therefore should be categorised independently. Arber and Ginn (1993) compared the conventional approach with the individualistic approach in a study of older women's health. They found no clear advantage in using the conventional approach and further states that using the individualistic approach is conceptually clearer.

Abbott and Sapsford (1987) are concerned that the individualistic approach would take little or no account of the limitations of childbirth and child rearing on women's careers. Current occupation may not be a true reflection of class if, due to interruptions, women do not reach career grades they would have done if they had been men. Women who take career breaks tend to suffer loss in status and on average they do not catch up with their pre-break level. (Central Statistical Office 1995).

Women who are unemployed would have to use their last occupation for categorisation purposes. Arber (1990) questions the validity of using last employment for someone who may not have been employed for many years. It is, however, the current system used and accepted for males that are unemployed. Men who are not employed are never classified according to their wife's occupation Delphy (1984).

One of the major problems of using the individualistic approach is that the structure of women's employment differs from men's and fitting women into existing classification systems

which represent men's employment presents problems. In conventional scales women's employment is concentrated into a few occupational categories (Abbott and Sapsford 1987, Barker & Roberts 1990). It combines into single groups women with quite different occupations. These different occupations will inevitably have quite different work conditions and varying levels of remuneration. Abbott and Sapsford (1987) give the example of the classification of nurses who are all grouped together whether they be untrained or senior managers.

The manual / non manual divide in class III of the Registrar General's Classification presents one of the greatest difficulties when trying to fit women into conventional scales. This divide was originated for male occupations and is useful because it is clearly correlated to both market and work situations in men's jobs. However, unlike men, women in routine non-manual jobs tend to hold positions which in terms of their market position, and their work conditions, ie. promotion prospects, responsibility and degree of autonomy, are largely similar to men in manual occupations. These women, who would be classified as non-manual, can therefore be considered effectively working class (Goldthorpe 1983, Giddens 1981, Britten and Heath 1983).

The vast numbers of women employed in shop and office work are clumped together in class IIINM even though the two occupations require different qualifications and levels of skill and, offer different working conditions (Dale *et al* 1985).

Classifications Devised for Women

Attempts have been made to produce a scale appropriate for measuring the social class of women. Barker and Roberts (1990) devised a scheme based on what a woman does. They added household work, concerned with the care of children or the elderly, to conventional scales of occupation. It is a complex system which offers the opportunity to use an individualistic approach and deal with those women who are not in paid employment. However its weakness, as indicated by Barker and Roberts (1990), is its treatment of housewives as a

homogenous group which may disguise the real differences in their life chances.

Dale *et al* (1985) have devised a scale which attempts to deal with women's market position and overcame the problem of the differences in full and part time employment. Their definition of social class is based on a set of variables which reflects the market power of each occupation. The variables included are wage level, fringe benefits and level of educational qualifications. Occupations which are similar in respect of these variables cluster together to represent classes. They have devised different schemes for full and part time workers. Abbott and Sapsford (1987) have criticized this scale for its exclusion of men which therefore limits its usefulness in not being able to apply it to studies of both gender. Problems would also arise if there was a desire to make comparisons with previous studies using the traditional approach. However, Dale *et al* (1985) acknowledge that this is initial and exploratory work which needs further work to develop an operational classification system.

Martin and Roberts (1984) devised a classification for women for use in a survey of women's employment. They modified the Registrar General's social class classification to discriminate more finely among women's jobs. They did this by sub-dividing the categories into which women's jobs fall. They did not change the assignment of any occupation to a particular social class and their classification can be re-combined to form the original social classes for comparative purposes. Their occupational group classification can be seen in Table 1.

The significant revision in Martin and Roberts (1984) work has been in social class III where the non-manual category has been divided into clerical and sales occupations. This reflects more adequately the work conditions, remuneration and level of educational qualification typically held by members of those occupations. It makes a more appropriate division between middle and working class classification for women.

This schema, therefore, seems to suit the purposes of this study and will be used on the basis that:

- it is more ideologically sound in a study of women to define women by their own occupation rather than by their husband's

- ▶ by classifying a woman by her own social class it is more likely to capture her own life experience, education and imagery
- ▶ the use of a classification which more finely discriminates between women's jobs will produce a more accurate description of a woman's class position

Stereotypes of classes tend to focus on other variables than just occupation. The typical stereotype of middle class consists of people who are in non-manual jobs, are well educated and buy their own homes. In contrast the stereotypical working class image consists of people who have manual jobs, have less formal educational qualifications and rent their homes. It therefore seemed useful to collect details about education and home ownership as well as women's occupation (see Appendix 1).

The data indicated that fifteen of the eighteen middle class women interviewed in this study had continued their education beyond the statutory requirement, whereas, only three of the eighteen working class women had done so. There does, therefore, appear to be a strong correlation between education and women's social class. Home ownership also demonstrated some links. Of the eighteen middle class women fourteen owned their own homes in contrast to only nine of the working class women. This is, however, more likely to be affected by the social class of their partner as in all cases these were married women.

Table 1 Women's Occupational Groups (Reproduced from Martin and Roberts 1984)

Social class	
I	1. Professional occupations Barrister, solicitor, chartered and certified accountant, university teacher, doctor, dentist, physicist, chemist, pharmacist, dispensing optician, qualified engineer, architect, town planner, civil servant (assistant secretary level and above)
II	2. Teachers Primary and secondary school teacher, teachers in further and higher education (not universities), head teacher, nursery teacher, vocational and industrial trainer.
II	3. Nursing, medical and social occupations SRN, SEN, nursing auxiliary, midwife, health visitor, children's nurse, matron/superintendent, dental nurse, dietician, radiographer, physiotherapist, chiropodist, dispenser, medical technician, houseparent, welfare occupations (including social workers, occupational therapist.
II	4. Other intermediate non-manual occupations Civil servants (executive officer to senior principle and equivalent in central and local government), computer programmer, systems analyst, O & M analyst, librarian, surveyor, personnel officer, manager, self-employed farmer, shopkeeper, publican, hotelier, buyer, company secretary, author, writer, journalist, artist, designer, window-dresser, entertainer, musician, actress.
III	5. Clerical occupations Typist, secretary, shorthand writer, clerk, receptionist, personal assistant, cashier (not retail), telephonist, receptionist, office machine operator, computer operator, punch card operator, data processor, draughts woman, tracer, market research interviewer.
III	6. Shop assistants and related sales occupations People selling goods in wholesale or retail establishments, cashier in retail shop, check-out and cash and wrap operator, petrol pump attendant, sales representative, demonstrator, theatre/cinema usherette, programme seller, insurance agent.
III	7. Skilled occupations Hairdresser, manicurist, beautician, make-up artist, cook, domestic, institution housekeeper, nursery nurse, travel stewardess, ambulance women, van driver, baker, weaver, knitter, mender, darner, tailoress and dressmaker, (whole garment), clothing cutter, milliner, upholsterer, bookbinder, precision instrument maker and repairer, instrument assemblers, laboratory assistant, driving instructor, policewoman.
IV	8. Semi-skilled factory worker Assembler, packer, labeller, grader, sorter, inspector, machinist, machine operator, people wrapping, filling or sealing containers, spinner, doubler, twister, winder, reeler.
IV	9. Semi-skilled domestic work Waitress, barmaid, canteen assistant, childminder, playground or playgroup supervisor, nanny, au pair, home help, care attendant, ward orderly, housemaid, domestic worker.
IV	10. Other semi-skilled occupations Agricultural worker, groom, kennel maid, shelf-filler, bus conductress, ticket collector, postwoman, mail sorter, laundress, dry cleaner, presser, mail order agent, market trader, collecting saleswoman, traffic warden, telephone operator.
V	11. Unskilled occupations Cleaner, charwoman, kitchen hand, labourer, messenger

CHAPTER TWO

METHODOLOGY

Feminist Research

This study aimed to capture the reality of women's experience of gaining information about their health from health professionals. The choice of a feminist methodology seemed appropriate for this study which aimed to explore the experiences of women from the vantage point of women themselves. Prior to looking at the features of feminist research in relation to this work it is necessary to consider the concept of methodology. "Methodology is a theory and analysis of how research should proceed" (Harding 1987, p3).

Methodology is more than a research method, it is more philosophical and is value laden. It is not a technique but a way of viewing. Methodology encompasses the choice of method, but, it is also how that method is chosen and how it is used (Cook and Funow 1990). It raises epistemological issues, that is the assumptions that underpin knowledge.

Epistemology is the theory of knowledge and answers questions about what is legitimate knowledge and who can be the knower (Harding 1987). It concerns ways of gathering knowledge and who gathers it. It questions what kinds of things can be known and raises issues of the value of objective knowledge versus subjective knowledge. The traditional view that scientific knowledge is objective is questioned.

Maynard (1994 p.18) describes the feminist concern with epistemology as 'who knows what about whom and how is knowledge legitimatised'. Feminists have argued that traditional epistemologies exclude the possibility of women as knowers and claim the voice of science is the dominant male. Objectivity has been equated with masculinity, the assumption that to be objective requires a distancing and detachment both emotionally and

intellectually (Keller 1985). Feminists have proposed alternative theories of knowledge which legitimate women as the knowers (Harding 1987).

Research conducted from a feminist standpoint rejects the traditional patriarchal view that research must be truly objective. It is accepted that the researcher's cultural background has bearing and that it is not possible to take a totally objective stance. Stanley and Wise (1983) maintain that how researchers see and approach research is not a product of pure, uncontaminated factual occurrences. They claim that all occurrences are derived from our interpretation of them, and, in principal, objectivity is impossible to achieve in the sense that all research is constructed through the eyes of one person. The researcher is present in feminist research and should make that presence open. Keddy (1992) claims that feminist research should capitalise on the researchers' experience and feelings and allow it to guide the research.

A feminist methodology refers to research questions that are pertinent and of interest to women. Cook and Funow (1990) suggest that feminist research views women through a 'female prism'. Feminist enquiry begins from the perspective of women's experiences. It is argued that traditional research has been designed for men by men whereas feminist enquiry begins from the perspective of women's experiences. Past studies (Bruster *et al* 1994, Cortis & Lacey 1996) have attempted to measure satisfaction with the health information that patients receive using pre-defined quantitative measurement. In this study I aimed not to presume what it was that needed measuring but to explore the issue from the perspective of the women themselves. I wanted to explore what was the reality from their point of view.

Feminist research strives for an interactive approach through which the researcher and the researched are placed on the same plane (Harding 1987). The conduct of feminist enquiry aims to be non-hierarchical. It is research that is interactive and allows the participant's voice to be heard (Keddy 1992). It values women and provides a validation of women's experiences. Stanley and Wise (1983) emphasise that all research involves a relationship between the researcher and the researched. They claim that personhood cannot and should

not be left out of the research process. Feminist research calls for the relationships between researcher and respondent to be non-hierarchical. Feminist researchers talk of reciprocal relationships with informants. Oakley (1981) states that when she interviewed women in her study of mothers, her interviews were reciprocal, though Ribbens (1989) and McRobbie (1982) question the validity of this. This issue will be discussed in greater detail later when this chapter addresses ethical issues.

Feminist research, then, advocates the development of a different relationship between the researcher and the researched to the traditional approach. However, feminist research practice is arguably also useful for research practice as applied to human subjects in general. It is not only women interviewing women who might employ methods that are not oppressive to the researched, but, it should also be recognised as a formula for other research practice. McCormack (1981) points out that not all research by women on women is feminist in approach. While Harding (1987) states that there is no reason why men should not practice feminist research providing they put themselves on the same critical plane as their subjects.

Though it is argued (Siebold *et al* 1994) that producing a checklist for feminist research is not helpful as it may close options to innovative research, Hall and Stevens (1991) describe the distinguishing features of feminist research which are worth consideration in respect of this study:

1. the research question reflects the concerns of particular groups of women, and, their concerns are investigated by their diversity rather than by a standardised universal model;
2. the objectivists stance and anonymous invisible voice of enquiry are avoided in favour of a reflexive approach to enquiry;
3. feminist enquiry is done for the purpose of finding answers for women rather than for the medical profession or health care administration etc.

This study clearly demonstrates the first two features. That is, firstly women's experiences are the major objective of the investigation. Secondly, the goal is to capture the reality of the experience of receiving information from health professionals from the viewpoint of two particular groups of women. The research was carried out, in total, by myself. I accepted the part I played within the research process and have attempted to make my presence open. Research is always carried out from a particular standpoint and a reflexive analysis respects the different meanings brought to the research by the researcher (Parker 1994).

Prior to engaging with the informants I interviewed, I needed to reflect on my own role, how this would be perceived by the women I interviewed and how that might affect their response to me. I was asking them to talk about their communication with health professionals and therefore it was important to consider how they related to me. I initially introduced myself as a nurse researcher employed by a university department. I dressed casually so as not to appear as an official. Some women asked me what else I did at the university and I talked about my teaching of both health studies students and nursing students. I think in their eyes this detached me from the nurses they knew on the ward. In the process of the interviews, questions from the women indicated that they primarily saw me as researcher. I was asked why I was doing the research and how it would be used. I was also asked in general terms what I had learnt from talking to other women, but, I was rarely asked questions that related to my experience as a nurse.

In quantitative research truth value is assessed by the validity of the instruments employed and a research instrument is considered valid when there is confidence it measures what it is intended to measure. The truth value in qualitative research is the discovery of human experiences as they are perceived by the informants (Sandelowski 1986). The truth is informant oriented rather than defined by the researcher. Guba and Lincoln (1981) use the term credibility rather than internal validity to describe the truth value in qualitative research. A qualitative study is credible when it represents either faithful descriptions or interpretations of human experiences. To achieve this I needed to think about my approach and development of rapport with the women I was interviewing.

I had to consider how to approach the interview to put the interviewees at their ease and develop rapport. A feminist perspective in science values engagement with, rather than detachment from, the subjects being studied (Hall and Stevens 1991). Interviewing the women in their own homes and at their convenience was a step towards this. Most women preferred me to visit during the day and often commented that it was nice to have someone to talk to as they were often on their own all day during the recovery period. I made no stipulation that dogs, children or phones should be silenced as I considered myself a visitor in these women's homes. However, they did treat me as a guest and on most occasions answer phones were switched on and televisions were turned down if not off. Few of the women had young children, but, the presence of a large dog on one occasion may have affected my interviewing technique. On this occasion the woman concerned had asked me to visit in the evening and had taken the trouble to arrange for her husband to walk the dog whilst I was there. Though her husband and dog returned before we had finished talking and the presence of a very large, panting dog can be heard on the tape recorder as my responses diminish. However, the responses of these women indicated the involvement they invested in their participation in the research interviews and is pertinent to the validity of the study.

The development of trust and openness is necessary for credibility and for confidence that the research represents what is significant in women's lives (Hall and Stevens 1991). In order to gain rapport I spent time before the interview chatting and building a relationship. This often involved discussion about their families, work, homes or the weather. It also gave the women opportunity to ask questions of me and the research. On every occasion but one I was offered coffee and this was often accompanied by other refreshments. On several occasions I was offered sandwiches and on one occasion a curry. I felt this reflected the depth of relationship these women were willing to enter into and that I was treated as a friend rather than a visiting official.

I also had to consider what would in quantitative research be termed reliability. A reliable instrument is one that is consistent and dependable and produces comparable results every time. In contrast qualitative research emphasises the uniqueness of human experiences and

Guba and Lincoln (1981) suggest that auditability is a more appropriate criteria for rigour. By auditability they mean that another researcher should be able to clearly follow the research trail. Every effort has been made within this study to make the trail transparent so that it could be clearly followed by another researcher.

Who the research is for is a more difficult issue. This study will be published in professional journals for an audience of health professionals, but if health professionals are provided with the opportunity to read about issues of information giving from the perspective of women themselves, then, perhaps it could be described as for women. It could not, however, be described as for women in a political sense, but does take a feminist standpoint and draws on feminist methodology for the design and conduct of the study.

Qualitative Methodology

The purpose of both qualitative and quantitative research is to contribute to the knowledge of a subject, but there are essential differences between the methodologies. The quantitative approach emerged from positivism which is a school of thought that applies methods of natural science to the study of people and treats the social world as if it were an objective reality. Positivists assume that if a researcher looks down on a situation s/he can see it more clearly than the participants themselves. It takes a mechanistic approach that things can be categorised and counted by an external observer.

A positivist methodology seeks to discover laws using quantitative methods. It relies on direct observation, measurement and objectivity. It makes the assumption that human behaviour can be manipulated, measured and controlled. Theory and previous research puts positivist researchers into the position of knowing what they are looking for because they have a specific hypothesis to be tested (Robson 1994). Quantitative research starts with a theory and proceeds to test it.

Qualitative research describes and illuminates the social world as prescribed by the

interpretivist paradigm (Silverman 1994). A qualitative approach is based on the understanding that a person's behaviour is inextricably linked with the meaning that a situation had for her/him. Within a situation there will be different perspectives reflecting different experiences and understandings. There is no correct perspective but the researcher needs to gain understanding of the different perspectives. Our worlds are socially constructed and the only way to know a person's world is to know it from within.

Qualitative research is grounded in a philosophical position which is concerned with how the social world is interpreted, understood and experienced. It is based on methods of data generation which are flexible to the social context in which the data are produced. It aims to produce understanding on the basis of 'thick' description. This was a term used by the anthropologist Geertz (1973) and is a description that makes explicit the detailed patterns of social relationships and puts them into context. Denzin (1989) states that thick description includes the thoughts and perceptions that research participants experience.

Quantitative research would utilise pre-coded categories to gather data. These are based on the assumption that the researcher is sufficiently familiar with the phenomenon under investigation to be able to specify in advance the range of experiences being studied and are of limited use in trying to understand women's lives (Maynard 1994). When I set out on this research I wanted to find out the experiences women had of receiving information in hospital and how this differed in women of different class positions in society. I did not want to make assumptions that may reflect my experience rather than those of the women I was studying. Sociological research based on the assumption that the researcher knows what to measure is not exploratory (Maynard 1994).

To explore how class position in society affected women's experience it was essential to adopt an approach that allowed me to see their world from within. It is argued (Graham 1984) that the production of facts and figures fractures people's lives as only a tiny part of the experience is abstracted. Quantitative measurement would not convey the understanding of the women I was studying. It is important that the approach taken is the one most likely to yield relevant answers (Seibold *et al* 1993).

Feminist research utilises both quantitative and qualitative methodologies (Webb 1993), though qualitative approaches tend to predominate (King 1994). However, it may be a mistake to eliminate a quantitative approach. Oakley (1993) cites Davies and Esseveld's (1986) observations that if quantitative methods are rejected in feminist research, it bars discussion of the use of those methods to generate knowledge which maybe relevant to improving women's situation. Oakley (1993) states that a ban on any quantitative approach results in restriction to certain types of research question only.

For this study the use of a qualitative approach which focuses on subjective meanings and experiences is the most appropriate to address the research question.

Research Design

The design of this study was influenced by ethnographic research. Ethnography is often used interchangeably with qualitative research, but it is one form of qualitative research and has a long history. "The central aim of ethnography is to understand another way of life from the native point of view" (Spradley 1979 p.3).

The aim of ethnographic research is to gain understanding of the emic perspective. In ethnographic terms the emic perspective is that of the insider or informant while the etic perspective describes the outsider. The emic perspective explains events from the informants point of view, it is the informants definition of the situation or experience. Holloway and Wheeler (1997) suggest that for far too long the etic perspective has led to health care research and health professionals defining and describing patient's problems. This research was to capture the emic perspective of women undergoing gynaecological surgery, to explore what was their experience of communication with health professionals. I wanted to adopt the principle of being a 'radically naive observer' (Atkinson 1992), someone who is not willing to assume connections that have been suggested by others.

I was interested in women's experiences in encounters with both the nursing and medical professions, but recognised that women are not a homogenous group. Women's lives are

not shaped exclusively by gender (Hall & Stevens 1991). Their values, beliefs, experiences and interpretations will vary according to the social group they are in. In this study I wanted to explore if and how class position affected their interaction with health professionals. The recognition of cultural influences on individuals and groups helps to conceptualise their behaviour and beliefs and values (Holloway and Wheeler 1997).

Ethnographic research enables the researcher to recognise cultural influences on individuals. In a culture or sub-culture individuals hold common values and beliefs learnt through the process of socialisation. In order to understand a group's culture it is necessary for the researcher to study it as it is. A person's behaviour is inextricably linked with the meaning a situation has for her and has to be understood in the light of the broader organisation or culture.

The use of an ethnographic design for this study was not, however, without its problems. Ethnography has its roots in social anthropology and was used by famous anthropologists to explore tribal groups (Malinowski 1922, Mead 1935). Sociology later adopted ethnography and it has been used to study cultures and sub cultures within western society, one of the most well known being Whyte's (1943) study of urban gang sub-culture in a small community in Chicago. In more recent years ethnographic designs have been employed to study health and health behaviours and the influence of ethnography can be seen within nursing research, one of the most well known being Leninger's (1978) study of transcultural nursing.

But differences exist between traditional ethnographic studies and nursing ethnography. Anthropologists spent many months, or even years, living with and participating with the groups they were studying. In anthropology lengthy observation was essential partly because of language differences between the researcher and the informants. Morse (1991) questioned the use of ethnography to study nursing and expressed concern about the unit of analysis. While the traditional ethnographer studied a tribe or village, in nursing the unit was a ward or a group of patients with a similar disease or symptoms. Because individuals are together in a hospital ward does not necessarily mean they share a common culture, and this study aimed to question, does a woman's position in society affect the experience

she has in hospital?

Participant observation, the data collection method most commonly employed in ethnographic research is not by any means standard in nursing research (Steubert and Carpenter 1995). Holloway and Wheeler (1997) suggest this is in part because language differences do not exist, and other aspects of culture such as structure and environmental context are as important as language. But, Morse (1991) maintains that participant observation is an essential component of ethnography and research which does not employ this method cannot be considered ethnography.

In this study observation presented some very practical difficulties. To observe the process of information giving in hospital it would have been difficult to identify an appropriate time to capture the communication process, particularly in the light of some of the findings. Although observation might feasibly have taken place within the out patient department I felt that would restrict the totality of the experience that I aimed to capture. Therefore, in-depth interviews were employed to explore the experience from the women's perspective.

There is some conflict in the discussion of the use of ethnography in feminist research. Stacey (1988) expressed concern that the intensive involvement of the ethnographer with her informants can lead to risks of exploitation and abandonment of the researched by the researcher. Though Skeggs (1994) believes that Stacey overstates the power of the researcher and claims that in her study of young women in further education her informants enjoyed participating in the research, and the research was only ever a small part of their lives. Skeggs (1994) claims that principles and power will inform any research project and argues that feminist ethnography forces the researcher to confront the issues. Williams (1995) also believes feminist ethnography can be productive, although there may be some difficulty in applying feminist principles.

This study, then, is not in the traditional sense ethnographic research, but it does aim to describe an experience from the women's point of view within the context of their culturally constituted environment. In-depth interviews were shaped by Spradley's (1979) format for ethnographic interviews, and inductive analysis was employed to describe how

the experience of receiving health education information is influenced by class position in society. Data collection from health professionals also helped to provide insight into the organisational setting. There has been an increasing adoption of ethnographic methods by social scientists within health care and Hammersly and Atkinson (1994) suggest that a rigid approach to ethnography should be avoided.

Study Population

Phase one

The study population was composed of women undergoing hysterectomy or hysterectomy and oophorectomy. In terms of experience of surgery and process of recovery there is little to distinguish between the types of surgery above. One significant difference is, of course, the debate about HRT for women who have had their ovaries removed. On reflection, by including these women it has added to the breadth of the information obtained. Women that were omitted from the study were those who had undergone surgery for malignant conditions as this would affect their experience and feelings about their surgery and recovery.

Women who did not speak English were also excluded. While it is recognised that class position is relevant to race and culture, the difficulties and cost of employing an interpreter plus the issues of confidentiality made it impossible. However, one woman I approached, who was of Greek nationality, understood English but had difficulty expressing herself, but following my explanation she was keen to be included and arranged for her daughter to be present to help her express her feelings.

Three centres were chosen for the study on the basis that, although the purpose of qualitative research is not generalisation (Field and Morse 1996), it would be useful to be able to avoid the conclusion that findings were peculiar to one particular centre. The centres chosen were divergent in terms of location. All three hospitals were district general hospitals and were similar in size. One could be described as being situated in the leafy suburbs in the South East, whilst the other two were in urban settings, one was in the

North West of the country whilst the other one was within London. These hospitals have not been identified to protect the anonymity of the informants.

All three hospitals had dedicated gynaecological wards and the wards were similar in number of beds and number of hysterectomies performed per week. Each of the gynaecological units were served by a number of gynaecological consultants and each centre had both male and female consultants. None of the wards had male nursing staff in employment.

Phase two

The study population for this part of the study were nurses and doctors employed at the three centres above. Nurses included registered or enrolled nurses of any grade employed on the gynaecological ward. Nursing care assistants were not included as it is the responsibility of the qualified nurse to provide health information education. Doctors included gynaecological surgeons at either senior registrar or consultant level. Doctors below this level could not be considered sufficiently experienced in the speciality and would not have been responsible for decision making about this type of surgery.

Sample

Phase one

The strategy for sampling was guided by the need for rich data. A non-probability sample was chosen as it is deemed acceptable for qualitative research (Polit & Hungler 1995). A strategy of quota sampling, a form of non-probability sampling was used to guide the selection of informants such that the final sample included the correct number of cases from each of the social class positions (see Table 2).

The sample of women for this study was obtained by random visits to each of the three centres to recruit women who were on the wards undergoing hysterectomy and willing to consent to join the study. The sample consisted of thirty six women in total, drawn in equal

numbers in each class position from each of the three centres (see Table 2).

QUOTA SAMPLE		
	working class	middle class
centre one	6	6
centre two	6	6
centre three	6	6

Table 2

Class position was measured by the woman's occupation. If she was not employed then her last occupation was taken as the measure. Full discussion of this issue is in Chapter 1.

Ethical Issues

Informed consent was obtained for all participants in the study.

“Informed consent means that subjects have adequate information regarding the research; are capable of comprehending the information; and have the power of free choice, enabling them to voluntarily consent or decline participation in the research”

(Polit & Hungler 1995 p.125)

To ensure that all potential subjects were fully informed of the research before consenting I undertook to visit them all and provide information myself. Access to the women was gained by visiting the gynaecological wards at each centre and seeking information, from the nurse in charge, of the names of women that were undergoing hysterectomy or hysterectomy and oophorectomy. I was also advised by the nurse whether the women were well enough to be approached.

I approached the appropriate women and provided them with a letter (see Appendix 2) plus a question and answer sheet (see Appendix 3) informing them about the research. These documents indicated the purpose of the study, the nature of the commitment and the right to privacy and withdrawal from the study.

I allowed time for the women to read the information and then returned to see if they indicated interest. If so, I provided verbal information and answered any questions that they had. Following this, if the woman was willing to become a participant we made an appointment for an interview at her own home, at a time convenient to her, between six and ten weeks following discharge from hospital. I also asked her to sign a consent form (see Appendix 4). A telephone number was provided so that she could contact me should she wish to withdraw, alter the time or require any further information.

All the women were informed that they would not be identified in any way and all tapes were given a code and pseudonym.

Phase two

The strategy of sampling health professionals was one of convenience. A convenience sample is the use of the most conveniently available people for the study (Polit & Hungler 1995). The aim was to recruit both nurses and gynaecologists from each of the three study centres.

At each of the centres I spent half a day, pre-arranged with the ward staff and at their convenience, to interview nurses who were eligible for the sample and willing to consent. All the nurses I approached agreed to be interviewed. They ranged from junior staff nurse to senior staff nurse and senior enrolled nurse. Ward sisters were not included in the sample because they were either off duty or informed me that they were too busy to be included. In total eight nurses were interviewed, four from one centre and two from each of the other centres.

Two gynaecologists at each centre were written to and asked if they would take part in an

interview. At two of the centres both of those approached agreed. At the third centre although initial consent by both was given, one cancelled the appointment and then did not respond to further calls, whilst the other, despite several calls to the secretary, never provided a date and time. Therefore the sample included gynaecologists from only two centres. In both samples of health professionals there was some element of self selection and this could be reflected in the findings.

Method

Phase one

Informal, in-depth interviews were chosen as a data collection method. In qualitative research the interview provides for the mutual sharing of information. The aim of the interview is to gain an authentic understanding of experiences and the way that social worlds are constructed (Silverman 1994). The time frame was unconstrained and there was opportunity for clarification and exploration of pertinent issues as they arose. The in-depth interview allows respondents to raise issues that the researcher may not have anticipated at the outset of the research.

The interview was shaped by the ethnographic interview format which aims to describe cultural meanings that exist within a group. Spradley (1979) described it as informal conversation with a research agenda. It incorporates a particular style in which the interviewer is responsive to the information and cues the informant provides. The interviewer is interested in what people think and compares one person's perspective with another to identify shared values among members of a cultural group (Sorrell & Redmond 1995). The aim is to gain the emic perspective which includes the ideas, beliefs and knowledge of the social group.

Prior to the research interview I had visited all the women whilst they were in hospital and was therefore able to prepare them for the future interview. It provided them with the opportunity to know and recognise me when I later knocked on their door, and, it also gave them some idea of the nature of the information I would be seeking. Interviews were

carried out in the woman's own home and at her convenience.

The interviews themselves were always preceded by a period of conversation which was not directly concerned with the business of the interview. This period lasted between fifteen to forty five minutes. Invariably I was offered coffee, and often cakes, and some considerable time was spent in conversation about a variety of issues. A 'warm up' period enhances the build up of rapport and trust (Sorrell and Redmond 1995) and interaction between the researcher and researched enriches the data that emerges.

Sorrell and Redmond (1995) suggest three major types of questions used in ethnographic interviews based on Spradley's (1979) work:

1. Grand tour question - descriptive open ended question which give the researcher a general view of the informants perspective.
2. Structural questions - provide more specific cultural information which can also be used to ask for explanations
3. Contrast questions - help the interview understand the meanings of words the informants use

This was used as a guide for the format of the interviews. I began by asking women to describe their experience and later focused on issues of structure and contrast.

Permission to use a tape recorder was requested at the beginning of each interview. I informed the women that their identity would be protected and that the tapes would be destroyed at the end of the study. None of the women objected to the use of the tape recorder.

Ethical Issues

As a feminist researcher I was also guided by feminist principles of interviewing in a non-

hierarchical and reciprocal manner. Oakley (1993) argues that the traditional approach to research interviews in which the researcher remains detached and non-committal is morally indefensible. She also suggests that the goal of finding out about people is best achieved when the relationship between researcher and informant is non-hierarchical and the researcher invests her personal identity in the relationship. This is also in accordance with ethnographic interviews which incorporate a free flowing approach in which the interviewer is responsive to the information provided by the informant (Hughes 1992).

I therefore attempted to adopt a non-hierarchical approach, but have to question the reality of this. McRobbie (1982) claimed that Oakley (1981) failed to recognise the way in which the researcher has everything going for her, and asks whether women are good research informants because of their willingness to talk, which is in fact an indication of their powerlessness. Inevitably my own role raised just these questions. Firstly, the words of many women as I left were 'it has been so good to talk to you' and, indeed, the research findings indicate that these women lacked someone to talk to. So, was I fulfilling a role that busy health professionals had failed to do and, if so, did that prevent us from being on the same plane?

Secondly, I am a nurse and lecturer in higher education and as such represent authority to many of the women I interviewed. This is particularly significant as the findings indicate that the women talked of powerlessness in their relationships with health professionals. Although the information they gave me indicated that they were willing to talk to me in a way that they had not done with doctors and nurses, it still leaves some doubt as to whether this could be described as a non-hierarchical relationship.

I did, however, try to minimise inconvenience and disruption by interviewing women in their own homes. When interviewing in the informant's own setting Field and Morse (1996) advise asking informants to arrange child care and unplug phones to minimise disruption. As this was not in accordance with feminist research (Oakley 1981) I chose not to make these impositions. Few of the women I interviewed had young children but when they were present their interruptions were part of the every day experience for these women and did not significantly disturb the interview. Although phones did occasionally ring, I felt I did

not have the right to disrupt women's lives.

Reciprocity within the interviews was easier to address. Oakley (1981) , in her study of mothers, reports that she gave information based on her own experience when women asked questions of her. Though, Ribbens (1989) questions if this was reciprocity when it was based on factual information rather than feelings and things of a more personal nature. Webb (1984), in her study of women undergoing hysterectomy, shared her experiences as a gynaecological patient and claimed it had a positive effect and encouraged rapport. She had also been a ward sister in gynaecology and was able to answer questions of a more technical nature.

I was prepared to do my best to respond to questions women asked and stated so in my research proposal. The reaction of one of the ethics committees to this was that, in granting approval, they wrote that I should not give any 'clinical' information. They obviously did not trust my integrity as a registered nurse to assure that any response I made was appropriate. Generally the questions I was asked were not of a clinical nature and I was able to draw on my experience as a female to make my response. If women asked me questions I could not answer then I did have advice for where they could gain that information. One woman I interviewed expressed anxiety at not having a leaflet as they had run out the day she was discharged. I was able to obtain one from the ward and post it on to her.

Phase two

The purpose of this part of the data collection was to gain some insight into the views of health professionals to provide a background to the study. It was carried out following the interviews with the women so that it would not influence the findings of phase one of the study.

The interviews with doctors and nurses were of a semi-structured format in which the topics were introduced by the researcher (see Appendices 5&6). The same topics were covered with each of the respondents, but not always in the same order and pertinent issues were explored as they arose. The interviews with the nurses took place in the hospital

wards where quiet areas were provided. The interviews with the gynaecologists took place in their own offices.

My role in these interviews required some consideration. To the doctors I introduced myself as a lecturer and this was not problematic. With the nurses I felt it was not as straightforward. They were aware that I was a lecturer and that this included nurse education. I, therefore, took some time to explain that I was not examining their practice, but was interested in their views.

Permission to use a tape recorder was requested at the beginning of each interview. Subjects were informed that both their own identity and the identity of the hospital would be protected, and that the tapes would be destroyed at the end of the study. All of the informants granted permission to use the tape recorder.

Data Analysis

Phase one

There are no universal rules or clear set of conventions for qualitative analysis but the data needs to be dealt with in a systematic way. The techniques used in this study have been influenced by Miles and Huberman (1994). The raw data for this study was in the form of tape recordings of interviews. Analysis began and continued during data collection.

Following the completion of an interview the tape was coded and given a pseudonym. Analysis began with repeated listening to the tapes to familiarise myself with the content and the context of the interview as suggested by Field and Morse (1996). I came to know the voices and the content of the interviews so well that on listening to any tape I could immediately recall both the name of the informant and the setting of the interview.

I transcribed verbatim two of the early tapes. This was not only time consuming but also the meaning of the words was lost when presented in the written form. I, therefore, found it more meaningful to listen to the interview and selectively transcribed what seemed

appropriate. Skeggs (1994) states that re-listening to tapes is a lot more inspiring than re-reading transcripts and recommends selective transcription.

The next stage of analysis was first level coding. Miles and Huberman (1994) describe first level coding as attaching labels to groups of words. The codes are retrieval devices that allow the researcher to collect together instances of a particular kind. The codes are attached to 'chunks' of words and attribute a class of phenomena to a segment of text.

Second level coding then took place to group the initial codes into a smaller number of categories. For an example see Table 3. Miles and Huberman (1994) describe second level coding or pattern coding as a way of grouping segments of data from first level coding into a smaller number of sets. It pulls a lot of material together to form more meaningful units of analysis. Miles and Huberman (1994 p.69) describe four important functions of pattern coding:

1. It reduces large amounts of data into a smaller number of analytic units
2. It gets the researcher into analysis during fieldwork so that later fieldwork can become more focused
3. It helps the researcher elaborate a cognitive map, an evolving, more integrated scheme for understanding local incidents and interactions
4. It lays groundwork for cross case analysis by surfacing common themes.

DATA ANALYSIS		
First level coding		Category
doing the shopping	out-patients visit	managing recovery
doing the housework	knowing a nurse	
asking questions	advice from friends	
need for support	written information	
role of relatives	need for counselling	
what to expect	returning to work	
preparation for discharge	being in control	
following a plan	lifting	
pride in progress	mobility	
help at home	hearing stories	
activities	going out	

Table 3

From the second level coding recurring themes were identified which pulled together separate pieces of data. Identifying a theme means isolating something that happens a number of times and consistently happens in a specific way (Miles and Huberman 1994). Metaphors were then used as pattern or theme making devices. They are data reducing devices and are ways of connecting findings to theory (Miles and Huberman 1994). Negative cases were also looked for and identified within the findings. The major categories and themes identified in this study are illustrated in Table 4.

CATEGORIES	WORKING CLASS THEMES	MIDDLE CLASS THEMES
Explanation and decision making	Doctor knows best	On a conveyor belt
Managing recovery	Following the rules	On your own
Information for menopause and HRT	Prescription for HRT	It's my body

Table 4

Phase two

The semi-structured interview and data analysis for this part of the study was researcher led in order to examine issues raised in part one of the study.

Tape recordings of the semi-structured interviews with health professionals were listened to and then transcribed verbatim. First level coding identified segments of text that were then reduced to a smaller number of categories. In these semi-structured interviews the categories were closely related to the questions posed and are presented as the findings.

Presentation of Data

The essence of qualitative research is to capture the inner experience. It is not about contrasting individuals, but is a composite of their experience. Therefore, in the analysis

and discussion it will be described as such.

In qualitative research it is in the report that the researcher has the most power. Taylor (1996, p45) states that “the reflexive researcher must remain self-conscious as an author”. Methods for ensuring validity of qualitative analysis emphasise making the context visible to the research audience (Mason 1998). In an effort to demonstrate this I have used a method employed in psychotherapy of presenting reflection on the process, in parallel to excerpts of the data, to give insight to contextual decisions and actions.

Data analysis generated from interviews with health professionals will be presented separately. It is to be seen as a background to the major part of the study. Semi-structured interviews based on the themes which emerged from the data collected from the women were used to gain information from health professionals, and for this reason presentation of Chapter 4 will be of a different style, without the reflective comments.

CHAPTER THREE

DATA ANALYSIS - PHASE ONE

EXPLANATION AND DECISION MAKING

Hysterectomy is a term which in general use refers to removal of the womb. In medical terms a partial hysterectomy is the removal of two thirds of the uterus with the cervix left intact, a total hysterectomy is the removal of the entire uterus including the cervix.

When undergoing hysterectomy for a benign cause it is possible to remove just the uterus or the uterus plus the fallopian tubes and ovaries, a total hysterectomy with salpingo-oophorectomy. Current gynaecological opinion on this is divided. Removal of the ovaries in a post menopausal woman is not so problematic as the ovaries have ceased their biological function, though it is doubtless that for some women they still hold some sort of psychological purpose. For women who have not undergone the menopause removal of the ovaries means that the woman will cease to produce oestrogen which, it is now argued, provides a protective factor against heart disease (Stampfer *et al* 1991) and osteoporosis (Smith 1990). This has to be balanced against the benefit of removing both ovaries in order to prevent the possibility of ovarian cancer at a later date (Studd 1989).

Doctor Knows Best

When working class women talked about the surgery they had undergone they indicated that they received information about their operation from the gynaecologist they saw at the hospital. The doctor seen in outpatients was described as the major source of information. However, when they related the explanation they had received they did so in terms used by the gynaecologists, using words like 'a total', and demonstrated very little understanding of what these terms actually meant.

Excerpt from transcript

Reflective comment

R: "Was the operation explained to you?"
May: "he said to me you're going down for a total"

May used medical jargon when she talked about her operation, I wanted to explore her understanding

R: "did they talk to you about removing your ovaries?"
Pat: "they said a full hysterectomy that was it"

Pat expressed some confusion as she talked about her surgery, I wanted to clarify her understanding

The terms 'total' and 'full hysterectomy' were used by these women with no apparent understanding of what was involved in the operation. The use of medical jargon and lack of understanding of the surgery they were to undergo illustrates a lack of power these women experienced as patients and suggests medical dominance where the doctor's priorities dictate what transpires (Broom and Woodward 1996)

When I explored their understanding of these terms they were vague in their description of the operation they had undergone and indicated little understanding of what was involved. They described their operation as a hysterectomy and, only when asked more specifically what they understood had been removed, was any further information forthcoming. Sue was unsure and asked for help remembering what the surgery may have involved.

R: " Do you know what you had done?"
Sue: "they removed the cervix and um, um, I didn't have my ovaries removed. Er, what else is there?"

Sue demonstrated little knowledge of her surgery, I wanted to clarify the detail of her understanding

R: "there's the womb"

Sue: "yes I had the womb removed"

There was, however, no indication that these women were dissatisfied with the information

they received about their operation. They were anxious to indicate that the explanation they received was adequate for them and they also indicated an expression of gratitude for any information offered by the surgeon.

R: "did you want to know more?"

May: "I accepted that, I was happy with that"

Other working class women had demonstrated satisfaction with minimal information about their surgery. I wanted to know what May's expectations were of gaining information.

R: "did they discuss it with you?"

Pat: "I let them do what they wanted"

Examining whether Pat perceived she in fact had any choice regarding the extent of her surgery

R: "did you understand what was happening?"

Babs: "well I'm one of these that believes a little knowledge can be a dangerous thing. I think we all tend to complicate matters when we start thinking"

Exploring the extent of Babs' understanding of her surgery

Though these women exhibit a lack of concern regarding the details of their surgery it must be questioned whether this is a result of their resignation to a lack of power in medical consultation rather than any real desire not to be involved.

Babs indicated that her role as patient did not involve knowledge or understanding of the surgery she was to undergo. She demonstrated little confidence in her own ability to comprehend her operation and resigned herself to the notion that matters concerning her body were better dealt with by professionals. She acknowledged an acceptance of the role of passive patient and indicated her conviction that it was safer to maintain a role in which she relinquished power to the surgeons when it came to decisions about her operation.

Detailed information, then, was described as provoking anxiety and was unnecessary by these women. They indicated a fear that further knowledge would increase their level of anxiety. They indicated a belief that medical knowledge is out of their control and they deal with this by detaching themselves. This acceptance of powerlessness in their encounter with health professionals may also be a reflection of their past experiences. Babs had indicated that she had suffered with gynaecological problems for many years but had failed to be taken seriously by her GP. It was only when she had a change of GP that her complaints were dealt with.

Chris understood that she would have her tubes and ovaries removed as well as her uterus, but, she also expressed a lack of desire to concern herself with the details of the operation.

R: "What did you have done?"

Chris: "they took the whole lot.....they might as well take it all out in one go"

R: "did you understand what you were having done then?"

Chris: "I said to them as long as you put me out I don't care what you do"

Chris was using the sort of language we frequently hear in the media and I wanted to explore her understanding of these terms. She, however, seemed determined to demonstrate her compliance.

Chris did not respond to my question about her understanding of the surgery but expressed her lack of desire for any concern with the decision making regarding her surgery. Though it may be that this reflected her experience of ill health whilst waiting for surgery, and, her relief in gaining some help.

Working class women appeared to derive comfort from being able to rely on the doctor in this way and demonstrated desire for the gynaecologist to adopt a paternalistic role (Stewart and Roter 1989). This lack of desire for information about the surgery they were to undergo conflicts with previous research (Wallace 1985, Webb 1986, Bruster *et al* 1994) which suggests that individuals are dissatisfied with the explanation they receive about their surgery. Webb's (1986) sample of women were largely middle class but,

Bruster *et al* (1994) found that socio-economic status had no influence on the desire for information. However, Bruster *et al's* research was a large scale survey using questionnaires and the use of closed questions is more likely to produce positive, compliant responses.

The lack of power these women experienced was further demonstrated when they talked about decisions as to the extent of their surgery. They did not indicate any desire to be involved in decision making about the extent of their surgery. They had little knowledge of the advantages and disadvantages of retaining their ovaries and they demonstrated a desire for the gynaecologist to indicate what he thought was best.

R: "were you given a choice about whether your ovaries were removed?"

Trying to find May's perception of her level of freedom in decision making

May : "no, no, really no.....he said to me you're going down for a total, I was quite happy for them to take the lot away"

Sue: ".....yes, I had the womb removed but not the ovaries"

Sue had some knowledge of her surgery but as I tried to find out her level of participation, she seemed more keen to demonstrate her compliance

R: "was that your choice?"

Sue: "no it's what they decided"

Jo: "they left the cervix but took everything else"

When Jo talked about the details of her surgery she did not indicate that there were any choices and I wanted to explore this further.

R: " did you have any choice in that?"

Jo: "well they told me you know"

Sue and Jo used the term 'they' when they talked about receiving information about their surgery. They avoided the personal and spoke as if there was some invisible force. There was no indication that there had been any discussion or feeling of personal contact with the person who provided information about the operation. They talked about it in almost ritualistic terms.

These women indicated that they were satisfied to accept a passive role in respect of the decision making process regarding their surgery despite the increased emphasis on consumerism in health policy heralded by the NHS reforms in 1991. However, the notion of consumerism in the NHS is problematic because of the vulnerable position of consumers and, their passivity is perhaps a reflection of their experience of powerlessness at the interface of health care.

They exhibited, then, a desire for the doctor to exert dominance and they applied low patient control. Porter's (1990) study of the professional client interface also found women in gynaecology clinics often seemed uninterested in the major decisions about their health and bodies. Previous studies (Pendleton *et al* 1980, Waitzken 1985) have indicated that the more educated have been found to receive more information from doctors, and, physicians have been more likely to justify their choice of treatment to patients with university education than those who are less educated (Street 1991). Cockerham *et al* (1986) found that the most disadvantaged in society seemed to stand as passive recipients of professional health services.

The way in which language is used by individuals can convey assumptions about their underlying feelings. Many words in the English language have undergone change from their original meaning, tracing the etymology and history of words can be revelatory. Even though individuals are not conscious of the origins of words when they use them, tracing their meaning can reveal why they were chosen. When describing their surgery this group of working class women frequently used the terms 'they took' or 'take the lot away' when talking about the removal of the uterus and/or ovaries. The origins of the verb 'to take' are 'to seize' or 'to capture', thus, possibly a further indication of the underlying powerlessness these women experience as patients.

Chris: "they took the whole lot"

These expressions were used as women responded to questions about their surgery.

May: "I was happy for them to take the lot away"

While they used terms that indicated powerlessness, they did so contentedly,

Jo: "but took everything else perhaps indicating their view of reproductive life.

Helen: "they like taking it all"

Helen expressed the idea that doctors 'like' removing organs indicating her belief that surgeons will remove as much as possible. This reflects the notion of the 'curing' nature of medicine where the emphasis is on the biological aspects of disease and the view of surgery is a radical one in which organs are removed where necessary to prevent disease occurring.

Nora and Helen did express a desire to be involved in decision making and they had decided that they wished to keep their ovaries. However, they did not report any discussion of this with the gynaecologists, but had sought advice from friends and relatives.

R: "was that your choice?"

Nora: " they all insisted no,no,no, that was my god daughter and my sister, all of them said you don't want to do that, keep it if it's not faulty"

I was trying to examine Nora's perception of her freedom to participate in decision making but she demonstrated how she had been highly influenced by relatives who had provided her with somewhat alarmist advice.

R: "was it your choice?"

Helen: "I got a friend, she's a nurse and she advised me to leave it"

While I was examining Helen's perception of her freedom of choice her response indicated that she saw herself as powerless and still sought professional advice even though it had to come from a friend.

These decisions were reported as neither discussed nor challenged by the gynaecologists, though Helen felt that her decision was not really approved of. She was left with the feeling that there was a preference on the part of the surgeon to remove the uterus and the

ovaries. But she could not recall any discussion or information provided by him.

R: "did they make any comment?"

Helen: "Dr Brown said he thought it wasn't the best idea, I don't know why, he didn't give me an opinion, he just said it's up to me, apparently they like taking it all"

Helen related how she had made her own decision. This was not the expectation for someone in her class position and I wanted to examine the doctors reaction to this.

Whilst these women attempted to exert some control in the consultation process they do not report a relationship of mutuality as described by Stewart and Roter (1989). A relationship of mutuality is characterised by active involvement of the patient bringing their own experiences and expectations and the doctor participating with clinical skills and knowledge. In the case of the above women there is no report of discussion or a participative process. These women had gained their knowledge from sources other than health professionals and did not report having been given any further advice by their gynaecologist. They indicated that their decision was accepted but there was no exchange of information or health advice from either the medical or the nursing staff.

For Brenda and Pat the decision making process was less clearly defined. Pat knew she had undergone a full hysterectomy but did not understand the extent of this. She did not know that her ovaries had been removed until she visited her GP following discharge from hospital. In relating her experience she demonstrated more concern about not being able to answer the questions from her GP than her lack of knowledge of her operation. She accepted this as a decision made for her.

R: "what did you have done?"

Pat: "I had a hysterectomy. Then my GP was very surprised they took my ovaries away.....but, you know, I didn't even ask, I wasn't really, and, she said why were they taken away? I said I don't know really".

Examining whether Pat really did not understand or whether nothing had been discussed with her.

R: "Did they discuss it with you?"

Trying to find out if Pat felt that she did not have any real choice or if she did not want to make the decision herself.

Pat: " No, they said if they found anything they would take them, you know, that was it really, I let them do what they wanted"

R: "how did you feel about that?"

Pat: "um, I didn't want any more children so it didn't matter really"

When Brenda was relating her experience, although she referred to the decision as to whether or not her ovaries should be removed, she indicated that the discussion had taken place as she arrived in the anaesthetic room immediately prior to entering theatre. However, she did not draw attention to this point and demonstrated no concern. She, in a similar way to other women in this group, was anxious to have the decision made for her.

R: "you said you had your tubes and ovaries removed as well, was that your choice?"

Brenda had demonstrated an understanding of the nature of her surgery and I wanted to examine the extent to which she had participated in the discussion.

Brenda: "when I got down into the operating theatre I said well what are you going to do? He said, at your age, maybe another year or so, they wouldn't be any good to you anyway, I'll take the lot"

R: " would you have liked to talk about it beforehand?"

Examining whether she would have liked a more 'consultative' relationship with the doctor.

Brenda: "I was happy with that cause I had enough problems (laughter). I thought he knows what he's doing, you know, I'll leave it to him"

In approaching the topic at this stage of the proceedings there was little opportunity for real discussion. A feminist critique of the medical profession asserts that it exercises

patriarchal authority over women. Porter (1990) found that gynaecologists failed to give women information because they were of the opinion that women either do not understand what they are told or do not wish to know.

It was assumed that the doctor had the knowledge and expertise to make the decision and any contribution from the women involved was not considered worthwhile. What Stacey (1994) describes as 'people knowledge' containing a good deal of medical knowledge which has been acquired through experience, was not valued either by the health professionals or the women themselves. This sort of deference to the medical profession has been demonstrated in previous studies. Oakley (1980) found working class women more deferential to members of the medical profession than those in the middle classes.

The nurse was given no mention when working class women talked about decision making with regard to their surgery. When asked whether they would have found it useful to talk to a nurse none of the women demonstrated a positive response. They either did not consider this to be within the role of the nurse or, felt that nurses were too busy, a notion that is discussed also when women talk of their information for recovery. Nurses seem to go along with the patriarchal stance of their medical colleagues. Though, as May (1992b) points out, nurses are subject to bureaucratic rules and medical authority which prevents use of their own professional autonomy.

Conclusion

In medical consultation and decision making these women, at the lower end of the social class gradient, indicated that they accepted a passive role and they displayed deference to the medical profession. They indicated a lack of knowledge regarding their surgery and its consequences, but, did not demonstrate a desire to be involved in decision making. They described their relationship with the doctor as one where there was low patient control demonstrating a paternalistic relationship (Stewart & Roter 1989). The working class women who reported making their own decision demonstrated exertion of high patient

control. However, they indicated that the gynaecologist did not engage in discussion but merely accepted their request. So, although these women have adopted a consumerist approach they have done so without receiving information from health professionals. Table 5 demonstrates the opposing roles as patients that these women adopted in their relationship with doctors.

Overall working class women demonstrated little knowledge of the working of their own body and exhibited a fear that to do so would increase their anxiety. They described their surgery in terms they had heard at the hospital but displayed little understanding what these terms actually meant. They did not express dissatisfaction with their lack of knowledge and spoke favourably of the health professionals they had seen in consultations at the hospital. They made no recognition that their own life experience or knowledge of their own body could be of worth in the medical consultation.

The socialisation of these women at the lower end of the social class gradient appears to lead to acceptance of the dominant role of the medical profession (Friedson 1970). They described their acceptance of their powerlessness and indicated that they did not have any other expectation.

On a Conveyor Belt

Middle class women indicated that they expected an explanation of their surgery from the gynaecologist. They expressed an eagerness to have some understanding of their operation and expected this to be provided by the hospital. However, though they saw the gynaecologist prior to surgery, they expressed dissatisfaction with the level of explanation.

R: "did you feel you were given enough information about the operation?"

Joy: "I knew about the operation but I don't think they explained it properly"

Examining whether Joy felt she had sufficient information to participate in decision making

R: "did you feel prepared for your operation?"

Val: "I don't really remember anyone explaining"

I wanted to know if Val had been given sufficient information to prepare her for her surgery.

They indicated that they felt rushed when seen in the out-patient clinic and that there was insufficient time to have the level of discussion they required. Vicky and Sarah expressed concern about the way in which they felt they were rushed through with little time for consultation. They both used the expression 'on a conveyor belt' to express how they had felt.

R: "did you know what you were having done?"

Vicky: "yes, the nurse told me, the doctors just went off and left me, I couldn't believe it"

R: "mm"

Vicky: "I just felt like I was on a conveyor belt, next one in and out"

Vicky sounded angry when she talked about her surgery and I wanted to find out what was the cause of her anger.

R: "did you feel you had the opportunity to talk about it?"

Sarah: "no-one said do you want to talk about anything. I felt you were just on your own, another on the conveyor belt"

The literature indicates that women have indicated a desire to discuss the nature of their surgery and I wanted to explore this with Sarah.

The use of the term 'on a conveyor belt' symbolises the feeling of being a factory produced product indicating no feeling of individuality and a need to rush to let the next 'product' through. But these middle class women demonstrated a desire for information from their gynaecologists. This mirrors other studies (Suominen *et al* 1994, Tilley *et al*

1987, Wallace 1985) which report that individuals undergoing surgery preferred the explanation of the operation to be given by the doctor.

Women who indicated that they asked questions were able to report that they gained the information they desired. This reflects Street's (1991) findings that patients who asked more, received more information. Webb (1986) reported that a feature of interviews with women undergoing hysterectomy was their revelation of the lack of information about the nature of the surgery they were to undergo. Since then, the Patients Charter (DoH 1991), has stated that patients have the right to have their treatment fully explained, but, this was not reported to be the case with these women, and, was conveyed as a cause of disappointment.

The manner in which the doctors communicated information was also a matter of concern for these women whilst they were in hospital. They felt that the style the doctors used did not enhance communication. Sally, as seen above, had expressed dissatisfaction with the level of explanations she received, but she was also concerned about the style of communication when the doctor visited her in the hospital. She described how she was ignored when surgeons communicated with the nursing staff rather than talking directly to her. She felt that her presence or worth as patient was not acknowledged.

R: "you had some difficulty?"

Sally wanted to talk to the doctor but

*Sally: "..... it annoys me when they talk
about you to the nurses as if you're deaf and
dumb"*

indicated some dissatisfaction when she
had tried to do so, I wanted to explore
the reason for this.

Viv had some difficulty when talking about her operation. She was unable to remember the details of what she had been told about her surgery.

*Viv: " what he said about the operation I
just couldn't remember"*

When I explored why she had this difficulty she described how the gynaecologist had visited her post-operatively whilst the nurses were meeting her hygiene needs. Whilst the nurses continued to wash her the surgeon provided an explanation of her surgery. Neither the nurses nor the surgeon recognised the need to break with routine to provide for informational needs.

R: "it was difficult?"

Viv had been talked to by the doctor but was unable to recall the information, I wanted to find out why this was so.

Viv: "yes, the nurses were trying to clean me and give me a wash and then Mr Green came, and what they actually did I don't know much about"

Jean described her interaction with the surgeon as rushed, and also, that they were conducted in a language which she felt hindered communication. She found it difficult to understand what she called 'their way' of explaining things and felt there was a lack of time for explanations.

R: "they talked to you?"

The literature suggests there can be difficulty with communication between professionals and their patients, I wanted to examine Jean's understanding.

Jean: ".....the surgeons come to see you and, em, they explain in a certain way, but it's their way, and then that's it they're off"

The approach to communication adopted by the gynaecologists was not deemed as appropriate by these women. The use of medical language has been noted to hinder communication, and, although doctors report that they use everyday language when talking to patients, research has demonstrated this is not always so (Bourhis *et al* 1989). In failing to communicate with the patient directly, or at an inappropriate time, it would appear that the surgeon is confirming the asymmetrical relationship between doctor and patient described in medicalisation theory (Friedson 1970, Illich 1975, Zola 1972). This style is reported as inadequate for these women's informational needs.

Women in the middle class group who were older, 75 years to 82 years, described a different experience. They also indicated the gynaecologist was their source of information about their operation, but, they did not express dissatisfaction with the explanation they received. Lucy described how she was unsure of the surgery she was to undergo until she arrived at the pre-admission clinic. She described her surprise at hearing that she was to undergo hysterectomy but did not convey anxiety. She described how she felt this was a decision best left to the doctor and was anxious to express her gratitude for the treatment she received.

R: "was there anything you would have liked to know about what you were having done?"

Exploring my expectations that Lucy, as a middle class woman, would want more information about her surgery.

Lucy: "I was a bit surprised when they said hysterectomy, and er, I said oh well if that's got to be done. I felt perhaps grateful they were going to that trouble."

R: "Was there anything else you would have liked to know about what you were having done?"

Lucy: "If the doctor thinks that then that's okay with me."

Ivy was satisfied that she understood the operation, she had been provided with diagrams and talked about the surgery in terms of what parts of her anatomy were removed. When talking about the reason for surgery she demonstrated less understanding and described how she was unsure why a hysterectomy was necessary. However, she did not express this as a problem and described how she accepted the role of the patient.

R: "Could I ask you what you had done?"

Ivy: "I had a hysterectomy"

R: "what did you have removed?"

Ivy was the second of the older ladies I interviewed and I wanted to find out whether she expected a 'consultative'

<i>Ivy: "I had the ovaries taken away as well"</i>	relationship or if, like Lucy, she
<i>R: "were you given any choice in that?"</i>	indicated an acceptance of a passive
<i>Ivy: "well they advised, I mean they tell you</i>	role.
<i>what they are going to do. They took tests</i>	
<i>and said there was nothing wrong, and then</i>	
<i>they sent for me to go back, so what they</i>	
<i>found I don't know. Well, well it doesn't</i>	
<i>really matter, I've had that much done,</i>	
<i>they've taken more out of me than they've</i>	
<i>put back in"</i>	

These consultations were characterised by the traditional paternalistic approach of the doctor. Unlike their younger counterparts these women express contentment with the situation. This may be due to the fact that these older women would be more aware of the history of charitable care in this country prior to the introduction of the NHS in 1948. Also it has been conventional for the British to be deferential to authority, although this cultural trait is changing in modern society, these women would have been socialised into a traditional respect for authority. The stage of the life -cycle that people have reached also shapes their views of health and illness. In Blaxter and Paterson's (1982) study older women attached more significance to moral fibre and viewed illness as giving in. They also demonstrated an attitude of trust and gratitude in their dealings with the medical profession and were deferential and non-questioning.

When middle class women described how they increased their understanding of the surgery they described how they used questioning to find out where parts would be removed from and how they would be removed. This approach was also demonstrated by the health professional's use of diagrams and anatomical explanations.

<i>R: "did you ask questions?"</i>	Exploring the role that Eva adopted as a
<i>Eva: "I asked them exactly how they were</i>	patient.
<i>going to do it, they showed me diagrams</i>	

where they would be cutting”

R: “did you understand what you were having done?”

Alison: “they explained what they where going to do. They showed me diagrams where they would cutting”

I wanted to examine the level of understanding Alison had of her surgery - did she understand it`s consequences as well as the biological details?

Alison demonstrated her concept of the body as having a hole when an organ was removed. She demonstrated more interest in the hole than in the consequences of the removal of her ovaries.

Alison: “I even asked exactly what went in the hole”

On reflection I could have explored further Alison's notion of 'a hole'

The explanations the women provided reflected the information given by the doctors and nurses. It indicated that health professionals focussed on biological concepts of which they had knowledge and power. The women did not report the same detail when talking about the consequences of the removal of the uterus or ovaries.

When it came to making decisions about the extent of their surgery middle class women indicated a desire to be involved. They reported that they had made their own decision whether or not to keep their ovaries. They also indicated that there was little information forthcoming from the gynaecologists as to the advantages and disadvantages of having the ovaries removed. Joy had decided that she would want to keep her ovaries but indicated that she had received little information from the gynaecologists regarding the pros and cons of removing the ovaries.

R: “what did you understand about your surgery?”

Joy: “I had a hysterectomy and they left the ovaries”

Examining Joy’s level of knowledge about her surgery and its consequences

<i>R: "was that your decision"</i>	I wanted to know who Joy perceived to
<i>Joy: "yes, it was my decision"</i>	be the decision maker.
<i>R: "was it discussed with you at the hospital?"</i>	Examining whether Joy had achieved a
<i>Joy: "not properly really, I said I wanted the ovaries, they said okay"</i>	relationship of 'mutuality' with her doctor.

Viv also made her own decision to retain her ovaries and this was accepted without question by the consultant. Viv however went on to describe how she was offered advice by a doctor she described as the registrar who did the operation. But, she perceived the advice to be a persuasion to have her ovaries removed rather than a balanced discussion of the advantages and disadvantages.

<i>R: "did you choose to keep your ovaries?"</i>	Viv knew the details of her surgery but I
<i>Viv: "I told him if he can possibly leave my ovaries I don't want them removed"</i>	wanted to know her level of participation in decision making
<i>R: "mm"</i>	
<i>Viv: "he (consultant) said that's alright. But before the operation she also had a word with me, she said instead of having an operation afterwards, because a lot of people have that, why don't you have everything removed, out"</i>	
<i>R: "she?"</i>	
<i>Viv: "the registrar who did the operation"</i>	

Jane, however, did express satisfaction with her consultation with the gynaecologist. She described how she had received an explanation about the possible options for surgery and this enabled her to make an informed decision. She related this in contrast to a previous experience with a different consultant at another hospital where she had been very dissatisfied with the approach of the gynaecologist who she described as reluctant to

answer questions and unwilling to listen.

Jane: ".....I had questions I wanted to ask and she wouldn't answer questions, she was the surgeon, she was going to do the surgery and that was it, there were no other possibilities around treatment. I went to see Mr Black and he was totally different, he talked to me and explained to me. He explained to me all the different options"

R: "did you make a choice?"

Jane: "I had my ovaries left"

Jane explained how she had been given the information to make an informed choice and I wanted to find out the role she then adopted as a patient.

The experience Jane described indicates a relationship of mutuality (Stewart & Roter 1989). The gynaecologist brought knowledge and skill to the consultation which was then conducted on an equal partnership and there was opportunity for the exchanging of ideas.

Sally was aware of the options and made her own decision to keep her ovaries, but she related how this decision was conveyed to the gynaecologist immediately prior to going into theatre. Sally described how the surgeon approached her before she was taken into theatre and suggested that she had her ovaries removed.

R: "did you know exactly what they were going to do?"

Sally: "I knew there were a couple of things they could do. When I was actually on the, when they were taking me into into theatre."

R: "this discussion was just as you were going into theatre?"

Sally: "just before I was going in, before they actually took me in"

I was shocked by Sally's revelation of where the discussion took place and wanted to explore her feeling about this.

Unlike Brenda, who had undergone a similar experience related above, Sally expressed concern about the situation she found herself in. She felt that she had not been provided with sufficient information prior to going down to theatre and she described this as frightening. Although she underwent elective surgery she described the event as being rushed with insufficient time for discussion.

R: "was it discussed before going to theatre?"

Sally: "nobody discussed it with me beforehand, it was all in such a rush. I do feel there is not enough said.....it's a bit frightening."

The time and place of the discussion indicated a patriarchal attitude on the part of the surgeon and I wanted to examine Sally's feelings about this style of relationship.

Holding a discussion outside of the operating theatre just prior to surgery indicates a failure on the part of the surgeon to take seriously the contribution a woman may make to the decision as to whether or not her ovaries are removed. This appears to be further evidence of a patriarchal approach over women on the part of the medical profession. These middle class women have indicated a desire to understand and be involved in their treatment. This may be an indication of their wider social knowledge. The media, which nowadays includes the Internet, plays some part in providing health care information. Though women were able to make their own decision, this was done without the advice and support of the gynaecologists that a relationship of mutuality (Stewart and Roter 1989) would have provided.

Conclusion

Middle class women described an understanding of their surgery, but did not report satisfaction with the explanations they received from gynaecologists. They demonstrated a need for more information and they expected this information to be forthcoming from the gynaecologists. When they talked of explanations of surgery they adopted a reductionist

approach and focussed on anatomical facts rather than physiological outcomes. This is also emphasised in the explanations provided by health professionals which are often described in terms of what is removed and the use of diagrams to demonstrate this. There is an indication that health professionals focus on biological concepts over which they have knowledge and control, but, do not discuss the implications in terms of health gains and losses.

In decision making the women described situations where, as patients, they exerted an active role but described the gynaecologist as acceding to their request rather than participating in frank discussion of the facts. This relationship between these women and their gynaecologists could be described as consumerist (Stewart and Roter 1989) but it lacked the engagement of the gynaecologist. Jane did report a discussion of the options available and was able to make her own decision based on this. Jane is the only woman that reported a doctor patient relationship based on mutuality.

Older women in the middle class group of women related a different experience. They demonstrated satisfaction with the explanations they received and indicated a belief that they need not be involved in decision making. They described a paternalistic relationship between themselves and their gynaecologist and, as can be seen in Table 5, indicated satisfaction with this in a similar way to the working class women

Nurses were not referred to by the women when they discussed explanations of their surgery. Discussion between the women and their gynaecologist was reported as unsatisfactory. Communication was hindered by the use of jargon and inappropriate choice of time and place. Inadequate discussion led to a lack of opportunity for these middle class women to be involved in decision making regarding their surgery and failed to provide a relationship of mutuality which they desired.

DECISION MAKING			
doctor patient relationship	working class women	middle class women	middle class women in older age group
paternalistic	<p>May: he said you're going down for a total</p> <p>Pat: they said a full hysterectomy that was it</p> <p>Sue: it's what they decided, I.....I didn't even ask</p> <p>Brenda: I thought he knows what he's doing</p> <p>Chris: They said it wasn't worth keeping them</p>	<p>Polly: he said it would be best for you to have the complete job done</p>	<p>Lucy: they said hysterectomy..I felt perhaps grateful</p> <p>Ivy: I had the ovaries taken, well they advised</p>
mutuality		<p>Jane: he explained all the options...I had my ovaries left</p>	
consumerist	<p>Helen: I left my ovaries....he said it's up to me</p> <p>Nora: I decided....he said it was okay</p>	<p>Viv: I didn't want them removed.....he said alright</p> <p>Sally: they were taking me into theatre when he said about taking the ovaries....I said leave them</p> <p>Joy: I said I wanted the ovaries ...they said okay</p> <p>Eva: I said....I wanted to keep them, the doctor told me to keep reminding them</p>	

Table 5

PAGE

NUMBERING

AS ORIGINAL

INFORMATION FOR MENOPAUSE AND HORMONE REPLACEMENT THERAPY

Women who have had their ovaries removed at the time of hysterectomy (hysterectomy and bilateral salpingo-oophorectomy) undergo what is termed a surgical menopause. Hormone replacement therapy (HRT) can be prescribed for relief of menopausal symptoms and/or for the long term health benefits. It is generally recognised as desirable for those women who are under forty years of age, and undergo a surgical menopause, to take hormone replacement therapy to prevent the increased risk of heart disease and osteoporosis caused by the withdrawal of oestrogen.

For women in their forties and fifties choosing whether or not to take HRT requires consideration of the possible benefits weighed against the potential risks. Benefits include the relief of menopausal symptoms and the prevention of osteoporosis and heart disease. As with any medication there are risks and side effects. There are still no definitive answers about the long term safety and efficacy of HRT (Hunter *et al* 1997). The most publicised risk is that of breast cancer, though, a recent study (Collaborative Group on Hormonal Factors in Breast Cancer 1997) indicates only a small increased risk for those women who have taken HRT for five years or more. Fairlie (1989) points out, however, that many women can be helped to deal with the loss of oestrogen in ways that don't involve taking HRT.

The women that talked about HRT in my interviews had either had their ovaries removed or were of an age where they had previously either been taking or considering taking HRT.

Prescription for HRT

Working class women reported nurses to be the main source of information regarding HRT. Though, when I explored the sort of information that the women had gained from nurses, they indicated that they understood the nurses as giving advice to take HRT rather than providing balanced information.

Babs: “.....the nurse came and talked to me, she explained you'll go on patches afterwards”

Chris: “.....I know I did talk to the nurses in there and they advised me to (take HRT)”

Although nurses were reported as having approached the topic of HRT there are indications that they have not taken the opportunity of providing balanced and informative health education to these women prior to discharge. Swiers (1996), in a study of women's knowledge of osteoporosis and HRT, also found that most women had not gained their information from health professionals, but from the mass media. While Roberts (1991) found women mostly gained their information of HRT from GP's and the mass media. Lack and Holloway (1992) in a study of fourteen women's knowledge of post-surgical HRT found them to be lacking in knowledge, but the social class of the women was not indicated.

Although an educative approach to empower women is advocated (Hampson & Hibbard 1996) these women do not appear to have benefited in terms of gaining information about the risks and benefits of HRT. Without relevant information these women are unable to participate in decision making, however, they did not voice any concern regarding this and expressed satisfaction when describing their talk with the nurse. As with explanations of surgery, nurses appear to adopt a patriarchal role. Lupton (1994) notes that the nurse's position as striving to know the whole person can be interpreted as surveillance and

disciplining of patient's bodies.

Working class women reported that the gynaecologist did not play a part either in the prescription of HRT or advising as to whether or not to take it. The only mention made of the gynaecologist in reference to HRT was linked with the decision as to the extent of the surgery discussed at the out-patient clinic. They did not recall discussion of HRT with the doctor at the hospital. The way in which women demonstrated little expectation of discussion with doctors about this topic reflects their attitude to their expectations of receiving information about their surgery.

Working class women reported that they had been prescribed HRT, but gave little indication of any knowledge that this was an option rather than essential. Although none of these women were below 43 years of age they described their prescription for HRT as if it were essential, rather than an option which has been demonstrated to have some effect on symptom relief and long term health gains to be balanced against recognized side effects.

They demonstrated an attitude towards their prescription for HRT which was similar to that of their decision making regarding surgery. They indicated powerlessness and an acceptance of a passive role. They reported that they accepted their prescription for HRT as a matter of course with no indication that they were aware of alternatives.

May had been prescribed HRT on leaving hospital and talked very positively about the benefits of symptom relief, principally hot flushes. She demonstrated an understanding that it was essential to take HRT and was unaware that at her age it can be considered to be optional.

R: "what was your main reason for taking HRT?"

May: "I thought I had to take it, I thought it was something you took because you'd lost everything you know. I didn't know you didn't have to take it.

As May talked to me she gave me the impression that she felt it was essential for her to take HRT, I wanted to find out what her understanding was.

The main reason for taking HRT, described by working class women, was for the relief of the symptoms of hot flushes and night sweats.

*Pat: ".....I've been to the doctor and she's
put me on the pads, you know the little
HRT"*

<i>R: "who made the decision you should go on HRT?"</i>	Pat talked as if taking HRT was a decision made by her doctor, I wanted to
<i>Pat: "well I was getting very, very hot.....so she said to go on HRT"</i>	find out if she had any part in the decision

R: "are you taking any medication?"

*Chris: "they just advised me to have the
hormone replacement therapy.....I get
a lot of hot flushes"*

The above findings indicate the prevalence of the medical view of the menopause as a deficiency condition which requires treatment. Kadri (1990) in a survey of 187 GP's attitudes to HRT found that over half actively encouraged women to take HRT. Medical treatment with drugs is seen as a solution to a deficiency disease. Medicalisation theory in which doctors exert professional power (Friedson 1970, Illich 1975, Zola 1972) is again illustrated as was seen when discussing the findings regarding decision making and extent of surgery. Though, Daly (1995) notes that for women who experience difficulties during their menopause a 'disease construction' offers their best chance of help and treatment and this may be useful for some women.

Although Chris had described how she commenced HRT because of her hot flushes she did go on to demonstrate some knowledge of its long term benefits. She had gained this information from the nurses whilst she was in hospital.

R: "did it seem a good idea to you?"

Trying to find out at what level she had participated in the decision to take HRT

Chris: "well yes.....I did talk to the student and the nurse in there and they advised me to."

But other working class women indicated a lack of knowledge about the effects of the cessation of ovarian function on their body. They demonstrated little knowledge or understanding of the menopause in the same way as when they talked about their understanding of their surgery.

R: "how do you feel about taking HRT?"

Pat appeared confused about why she was taking HRT I wanted to examine her understanding of it

Pat: "I don't really know a lot about it I must admit, I'm a bit vague in that way, I don't really know anything about it I must admit"

Babs described how she had lacked understanding that she would continue with the menopause following her hysterectomy.

Babs: "you automatically think everything stops"

She reported that she was pleased that she had been informed by the nurse, whilst in hospital, that this wasn't so. She also described how the nurse went on to give her advice about HRT. However, the information she described was very much prescriptive and she indicated no knowledge of the advantages and disadvantages of HRT.

Babs: "she said you'll go on patches afterwards"

Working class women demonstrated an attitude towards their prescription for HRT that was similar to their attitude to decision making regarding surgery. They indicated an acceptance of a sick role (Parsons 1951) in which they remained passive patients. When

describing their lack of knowledge they also indicated an acceptance of a prescription for HRT as a matter of course. They talked about HRT in terms of symptom relief and indicated little knowledge of long term benefits. They reported discussion about the different preparations of HRT but not of its long term benefits and risks. There is evidence that they accepted their prescription for HRT as a matter of course with no indication that they were aware of alternatives.

Working class women who did not want to take HRT indicated that this was not about a fear of side effects or long term problems, but the notion that taking tablets is not good and is unnatural. They did not enter discussion about the possible problems with taking HRT but focussed on a dislike of medicines in general. They demonstrated an attitude that medicines were to be taken when one was ill, they gave no indication of knowledge of the possible health gains of preventative medicine.

R: "did you choose that?"

Nora: "I don't really like taking any sort of medication"

Nora and Helen had chosen not to take HRT, I wanted to know was this a need to be seen healthy, a denial of ill health, or concern about the drug itself.

R: "why is that?"

Helen: "but I don't like taking tablets..... I hate taking drugs"

R: "are you on HRT?"

Brenda: "no I won't"

R: "you're not going to?"

Brenda: "I'm not very keen on tablets"

Examining her reasons for refusing HRT and whether it was an informed choice.

Decisions about HRT may raise questions related to health beliefs and values of control over health. These working class women expressed the view that if there were no symptoms of ill health then medication was unnecessary and not natural, medication

indicates signs of ill health. Blaxter & Paterson (1982) found that working class women viewed health as the absence of illness. Hunter *et al* (1997) also indicated that HRT was not seen as unnatural when menopausal symptoms were the problem though, otherwise, women were found to be distrustful of hormonal medication and sometimes referred to the pill as a comparator.

Conclusion

In a similar approach to that of decision making regarding their surgery working class women described how they accepted a passive role in the medical consultation. They indicated that they received their information about the menopause and HRT from nurses rather than the gynaecologists. However, when relating the information they had received it was apparent they had perceived it to be advice to take HRT and they did not demonstrate understanding of the lack of ovarian function or the long term benefits and side effects of HRT.

HRT was regarded mainly as a prescription for the relief of symptoms. These women did not describe that their consideration of long term advantages and disadvantages had played any part in the decision. Those who indicated they did not want HRT described it in terms of a dislike of medication. They expressed the view that medication was for the relief of symptoms and demonstrated similar health beliefs to those of other working class women (Blaxter & Paterson 1982) that health is the absence of illness. They accepted their prescription for HRT as medical treatment and indicated that they exerted low patient control in decision making issues about their health.

It's My Body

Middle class women reported that HRT was prescribed without consultation. For them, this was an area of concern. They indicated that they felt they were prescribed HRT as a matter of routine and that it was assumed that they required it. Jean and Enid both

described how they felt they were prescribed HRT without adequate consultation and they indicated that they still lacked knowledge of its benefits and side effects.

Jean: "she just literally sat and wrote a prescription..... she didn't ask me if I wanted them"

R: "did they talk to you about HRT in hospital?"

Jean: "no they didn't really talk to me about it at all. There were plenty of leaflets around but you sort of have to root around yourself"

Although Jean challenged the lack of information she received I wanted to know if she had been able to do anything about it.

R: "as well as giving you a booklet did anyone talk to you in hospital?"

Enid: "Not really.....I didn't speak to anyone about HRT at all, em, I was just literally put on that"

Trying to find out if Enid, a middle class woman, was able to gain supplementary information when she was given a leaflet.

They expressed dissatisfaction with this situation and demonstrate an eagerness to be informed. Jean demonstrated some irritation when she talked about her lack of knowledge of HRT and its effects.

R: "you sound disappointed"

Jean: "I think from the professional side, I really did think you would get a little bit more information"

Jean expressed irritation when she talked about the lack of information, I wanted to know whose responsibility she thought this was

Enid also expressed a need for more information and felt that a referral to an appropriate clinic would have been useful.

R: "how did you feel about that?"

Enid expressed feelings of powerlessness and I wanted to explore how she felt in that situation.

Enid: "I felt really that maybe I should have an appointment at, you know, a clinic or something to discuss it but I was just given the tablets and told, you know, that's what you're going to take"

Vicky had made her own decision not to commence HRT. She expressed particular concern because she perceived that the doctors put her under pressure to take it, but she described how she had gained knowledge and made her own decision by reading material she had acquired herself. She did not refer to any information provided by the health professionals.

R: "have you started hormone replacement therapy?"

Vicky: "every time I've been to the hospital they want to start me on it. If they start coming out with all these good reasons, I think maybe I should do"

R: "you feel you know something about it?" Ascertaining what role Vicky felt she should play in decision making

Vicky: "that's it, I'm not ignorant, I've read all the articles. I am determined I am not going to take something I don't want"

Middle class women did demonstrate an awareness that HRT was an option following the menopause, surgical or otherwise, and they expressed disappointment in the lack of consultation with health professionals about HRT. They did not recall discussion of the benefits and side effects of the therapy. This mirrors Lack and Holloway's (1992) study in which a dominant theme for women talking about HRT post hysterectomy was uncertainty about what side effects could be.

The above findings indicate the prevalence of the medical view of the menopause as a deficiency condition that requires treatment. A normal feature of the female life cycle has increasingly become medicalized and redefined as a disease of endocrine deficiency (Helman 1997).

For middle class women who were hesitant to commence HRT the focus of concern was the link between HRT and breast cancer. Whilst overall they expressed concern about their lack of knowledge they did indicate an awareness of a slight increase in the risk of breast cancer when taking HRT. In the absence of detailed knowledge they indicated a reluctance to take a medication that had been demonstrated to have some risk involved.

<i>R: "you feel you know something about it?"</i>	Finding out how Vicky perceived her
<i>Vicky: ".....I don't want the risk of breast cancer, I know it's a very low risk"</i>	level of knowledge regarding HRT

<i>R: "was it something you considered?"</i>	Ascertaining Jane's contribution to the
<i>Jane: ".....I was a bit concerned because my sister had breast cancer"</i>	decision as to whether or not to take HRT

Jean reported how she was particularly worried about the side effects of HRT. As discussed earlier, Jean had expressed her disappointment at the paucity of information provided by health professionals. She had attempted to gain information from her GP proactively before she went into the hospital but described how she was seen by a locum who did not satisfy her informational needs. Her attempts to gain information from health professionals in hospital were also reported as unsuccessful. She described how she arrived home with a prescription for HRT, but expressed how she had remained anxious and had, subsequently, sought an alternative from the health shop.

<i>R: "have you decided if you will take them?"</i>	Jean expressed concern about HRT but had her prescription, I wanted to know how she would deal with this.
<i>Jean: "I think before I actually take these tablets I'll try them from the health shop"</i>	

Jean expressed some irritation that she had come home with a prescription for HRT and described how she felt she had lacked the opportunity to discuss her real concerns. She demonstrated resentment of the patriarchal role adopted by the gynaecologist and used the term 'it's my body' to express this.

Jean: " I thought it's my body, it's me that's got to cope with it"

Middle class women expressed a desire to have control over their own body. Feminists have argued that women should be offered alternatives to HRT, they should be better informed about the functioning of their bodies and encouraged to adopt healthy lifestyles (Worcester and Whatley 1992). However, this sort of discussion has not been reported by these middle class women.

Conclusion

Middle class women expressed dissatisfaction with the information they received regarding ovarian function and HRT. They were concerned about long term health gains and possible side effects of the drug, but described how they lacked the information to make an informed decision. They expressed a desire for information from health professionals and described their concern when this was not forthcoming. Neither doctors or nurses were described as providing the information that these women required. Although leaflets were available the women described how they had to be sought out by themselves.

They indicated that they adopted more active roles as patients (see Table 7) and expressed a desire for a consultation in which they could make an informed decision. However, they reported that the medical staff adopted a paternalistic approach (Stewart & Roter 1989). They expressed concern that they felt they lacked power to make informed decisions about their own bodies.

Table 7 illustrates the polarisation of roles that working class and middle class women

adopt as patients. Middle class women appear to adopt a more active role as patients than their working class counterparts. Negative cases are also illustrated.

WOMEN'S ROLE IN DECISION TO TAKE HRT		
Patient role	Working class women	Middle class women
active	Brenda: I'm not keen on tablets...I don't believe in being on it for a long time	Jean: I thought it's my body Vicky: I'm determined not to take something I don't want Eva: I didn't want to go on HRT straight away Jane: he talked to me about HRT which was something I was a bit concerned about
passive	Chris: they advised me to take HRT Babs: she explained you'll go on patches afterwards May: I didn't know I didn't have to take it Pat: so she said go on HRT...I don't really know a lot about it	Alison: I went on patches, HRT...my doctor's given them to me

Table 7

PAGE

NUMBERING

AS ORIGINAL

MANAGING RECOVERY

Average time spent in hospital for hysterectomy is currently approximately five days. This is followed by a period of recovery at home. During this time women make a gradual return to normal function. On average women return to work ten to twelve weeks following discharge from hospital. Although in certain cases this may be longer or shorter and will depend upon the type of occupation a woman has.

Following the Rules

When discussing their preparation for recovery working class women described leaflets as their major source of information. The leaflets were provided by the hospital and they contained guidelines as to when various activities could be undertaken following hysterectomy. They were written in the style of things to do and not to do post-operatively. Rationale for the actions were not included but the list of instructions was comprehensive and women described the leaflets as useful.

When working class woman talked about how they dealt with their own recovery they described the leaflets as sets of rules. They reported, with some pride, how they had rigidly followed what they described as the rules provided in their information leaflets.

R: "you said they gave you a leaflet?"
Chris: "the leaflet was actually a good
guide I think, I sort of stick to the rules"

I wanted to know if the leaflet had been explained, reflecting my concern about the use of leaflets without complementary advice

R: "how did you manage when you got home?"

Jill: "I'd get my list out and say look week such a thing I can do this"

Trying to find out how Jill used the information , did she follow the guidelines or did she use it to supplement her own decisions?

Babs described how she treated her guidelines as a bible. The use of the term 'bible' gives some insight into the importance Babs attached to the written information that she was given whilst in hospital. In Western society a bible is referred to as the word of God and contains commandments that govern behaviour. This gives an indication of the attitude that Babs adopted to the words of health professionals. She adopted a passive role in implying that the advice she was given was unquestionable. She further demonstrated this when she described how it had caused her some anxiety when the leaflet suggested she should take a trip to the local shops. The trip involved quite a distance, some of which was uphill, but, rather than deviate, she described how she had tried to comply.

R: "did you find it useful?"

Babs: "I treated it as a bible really you know, I'd get up and think it's my third week, I'll have a look and see what I can do this week."

R: "yes"

Babs: "on the note it says like you can go to the shops and do a bit of light shopping or buy a newspaper, well the nearest shops to us are in Newtown, so I said that's out of the question by the time I get there I'll be worn out. But I'd go out in the second week, which I knew I couldn't walk cause it was uphill, so I went by taxi and came back by taxi and just walked in the area I went to"

Exploring how Bab's used the written material she was provided with. Leaflets are acontextual and I wanted to know how useful they are without supplementary advice or discussion.

This rigid compliance, along with pride in making a good recovery, illustrates Parson's

(1951) concept of the sick role where the sick person is under obligation to seek help and conform with treatment. The patient enters into a relationship of dependancy and compliance in the service of getting well. For Parsons the relationship between doctor and patient is functional and complementary. Though critics (Friedson 1970, Bloor and Horobim 1975) argue that rather than the roles being complementary they hold potential conflict because of the social differences in power and knowledge. Medical practitioners have power because of their retention of medical knowledge. This group of women portray an acceptance of an asymmetrical relationship between themselves and health professionals.

At this stage it is worth giving some consideration as to how Babs perception of my role affected what she was telling me. Though I felt I had attempted to adopt a non-hierarchical stance I have to question whether Bab viewed me as some sort of official and, therefore, presented herself as a compliant patient. To assess this I again listened to the tape of the interview with Babs and was reminded of a later occurrence where she went on to tell me about the death of a friend some time ago which had affected her feelings. At this stage she broke down and we spent time discussing this. She also spoke critically of health professionals at some stages of the interview. I feel, therefore, that Babs did put more trust in me other than as a visiting professional and that the responses she provided were not necessarily those she wanted me to hear.

Although the leaflets were deemed to be informative, accurate and useful, Debra and Jo did express their concern that written information alone was not sufficient. They indicated a desire for verbal explanation to complement the leaflets.

R: "what sort of advise did they give you when you came home?"

Debra: "they give you a piece of paper about how long it should be before you do this and that...but they don't really discuss all of this"

The literature suggests that women are not prepared to deal with their recovery and I wanted to check this out

R: "how did they prepare you for coming home?"

Jo: "they didn't do anything really they just said you can go home today"

R: "were you told what you should do or not do?"

Jo: "I was given all these leaflets and that was it"

R: "were they useful?"

Jo: "they was alright, but I mean leaflets don't really put you at ease do they?"

Brenda and Ellen expressed some desire for a more individualistic approach and expressed dissatisfaction with what they considered to be too brief an explanation from nurses. When advice was given by nursing staff it was described as too general and lacking in the detail that was needed.

R: "when you were in hospital did they tell you what you could do?"

Brenda: "not really, I think that would be nice"

R: "did they go through your recovery?"

Brenda: "they said take it easy when you go home, but not enough really"

My own experience has also led me to question the way that patients are prepared for discharge.

Ellen had her daughter present when I interviewed her. She had requested this as English was not her first language and she told me that her daughter had helped her communicate with the health professionals. Although Ellen could understand English very well she was concerned that she had some difficulty in expressing herself. When I asked about information for recovery Ellen's daughter expressed some concern as she had actively sought out information to be able to assist her mother. However, she described her

disappointment with the quality of advice that she had received.

R: “.....and coming home. How were you prepared for coping during the recovery period?”

Ellen: “no information”

Ellen's daughter: “none of us were given any information about what to expect during recovery. I spoke to the ward sister just before she was discharged, just before we left..... and she gave me a very, very brief chat”

I wanted to explore any difficulties Ellen may have experienced because she found it difficult to express herself and also her cultural expectations may have been different to the norm.

These women reported that some emphasis was given to avoiding lifting but, again, this was described as being too vague to be of a lot of use.

Ellen's daughter: “.....the only thing they really said was no go to lift anything”

R: “when you came home did you know what you could and could not do?”

Dawn: “one of the nurses explained about lifting to me, but, I don't know when I can start doing certain things, how gradually to do it”

There was, then, a desire expressed for more specific information with which to manage their recovery. The information they gained from nurses was described as too vague to meet their needs. This reflects past studies (Webb 1986, Bernhard 1992, Suominen *et al* 1994, Bruster *et al* 1994) which demonstrated that hospital patients were dissatisfied with the quality and quantity of information they received regarding their recovery. Patients

nearing discharge from acute care have many informational needs as they take over their own management (McKay *et al* 1990). However, when women were given information it was reported to be of little use and consisted of vague generalisations similar to Webb's (1986) findings that information given consisted of snippets of advice which were vague.

Though the nurses were not perceived as providing sufficient information for coping at home, these working class women demonstrated anxiety not to be seen as critical of the nursing staff. They did not consider the nurses to be either unapproachable or unhelpful, but described them as being so very busy.

<i>Dawn: "there wasn't really anyone at the hospital to talk to"</i>	Exploring the experience of talking to nurses. Could they ask questions or were they put off by being rebuffed?
<i>R: "did you ask the nurses any questions?"</i>	
<i>Dawn: "not really, they're so busy you just don't like to bother them"</i>	

<i>R: "is there any other information you would have liked?"</i>
<i>Brenda: "they do try but I think in hospital you feel like you're in a queue and there's other people waiting"</i>

There was no blame apportioned to nurses for being unable to sit and talk to patients, and indeed, the women were very anxious to demonstrate this.

<i>R: "did they talk to you?"</i>	I wanted to examine the nurses' relationship with patients - were they pre-occupied with tasks to which they gave greater priority or were they avoiding questions they couldn't handle?
<i>Cath: "they did everything they could, they're angels those nurses, and they're a bit pushed aren't they?"</i>	

R: "You had difficulty in getting information?"

Sue: "they haven't got time to sit and talk to the patients, that's the tragic story about it, they haven't got time"

R: "what did they advise you at the hospital?"

Pat: "they didn't, it was a bit poor really..... they could have explained a bit more, but, they were brilliant, I couldn't fault them"

On reflection I considered how much the women's perceptions of my own role had prompted these responses. I had initially introduced myself as a nurse-researcher and, therefore, it was possible that the women felt the need to offer explanation of any criticism made of nurses. However, as suggested by Hall and Stevens (1991), I had spent some time in general conversation prior to the interview with the aim of building rapport. This talk had not involved my experience as a nurse and questions asked by the women indicated that they saw me as a researcher and did not ask me questions that referred to my role as a nurse. Therefore, I felt that this aspect of my role had not influenced their responses. It is perhaps rather more down to the public perception of the nurse's role within an overstretched health service.

Instead of health professionals, a major source of information for recovery for these women were their friends and relatives. When unable to gain advice from professionals these women turned to friends and relatives. Those that were described to be particularly helpful were the people who had undergone the operation and were therefore valued for their experience.

R: "was the information you were given useful?"

Nora: "to be quite honest no, because I've known from all the various people, the lady downstairs, my cousin, they've all been telling me things"

The literature suggests that women receive information that is vague, I wanted to know if this was so for these women.

R: "do you feel there was other information you would have liked?"

Bev: "I think I found out things before I went in, somebody at work had it done last year and she told me a lot"

Others had contacts that were recognised for their 'inside knowledge'. They worked in a hospital setting, though this did not have any direct relevance to gynaecology. Yet these women described how they actively sought information from these friends and relatives rather than trying to gain information from nurses in hospital who they considered were too busy with more important tasks.

R: "were you told to expect some pain?"

Ann: "I know a nurse that's there you see and she told me. She works with babies, she's worked there for years"

This sort of information can cause anxiety I wanted to find out where she had gained this information from.

R: "is there anything else you would have liked to have been told?"

May: "..... my sister that told me, she works in theatre"

Trying to examine whether she had been prepared to deal with her recovery or as the literature suggests did she have gaps in her knowledge?

R: "did you feel you had enough information for when you came home?"

Sue had been given some information prior to discharge but I wanted to know

Sue: "my sons fiancé, she's a ward manageress, and she gave me some leaflets as well" if she needed to supplement her knowledge

These women were actively seeking information. Though they expressed reluctance to ask questions of health professionals, which has been reported in other studies (Webb 1986, Ley 1988), they did attempt to gain advice from friends and relatives.

Previous studies (Bernhard 1992, Webb 1986) of women undergoing hysterectomy have produced similar findings. Bernhard (1992) indicated that women, all of whom were of low socio-economic status, largely gained their information about the operation from their mothers.

When I explored how the women had used this information they reported that information gained in this way was of limited use as different individuals can have very different experiences. The information given by friends and relatives was described as often being conflicting and misleading.

R: "did you feel prepared?" Nora demonstrated some knowledge for dealing with her recovery but I wanted to know how she felt about this.
Nora: "I've got at least six or seven friends who have had hysterectomy, each one of them told me a different story"

R: "did you understand what you should and should not do?" Pat appeared confused when she talked about the level of activity she could undertake, I wanted to clarify how she felt about this.
Pat: "..... I've got a friend, twelve weeks ago she had her operation and she said 'I'm still not lifting things' and I thought well should I be lifting things?"

This parallels other studies of women's' experience of hysterectomy. Bernhard (1992) found

that women talked to many different people and gained most information from their mothers. While Webb (1986) indicated that women had been told old wives tales leading to dissatisfaction. So whilst women describe friends and relatives as a source of information, they report that they do not fulfill this role satisfactorily and many women remain unclear and confused about issues regarding their recovery.

Conclusion

Women at the lower end of the social class gradient indicated that leaflets were their most satisfactory source of information for recovery (see Table 6). Leaflets were issued by hospital nurses and provided health education information written in the form of either advice or instructions. The women indicated that the leaflets provided a useful guide to activity levels during the recovery period. They described how they used the leaflets to guide their own activity following discharge from hospital and they referred to the leaflet as a set of rules to which they adhered. They indicated the acceptance of a passive role in their treatment and acted out the sick role (Parsons 1951) in following instructions provided by health professionals with the aim of enhancing recovery.

However, this group of women also reported a need for some more specific information which they indicated they believed should come from nurses. They expressed dissatisfaction with the information they gained from nursing staff (see Table 6), but, they were eager not to apportion blame. They described nurses as very busy with other tasks and were eager to praise their efforts. They indicated that in their perception nurses just did not have time to talk to patients and provide the information that they needed.

Working class women did also turn to friends and relatives for advice. However, advice they received was reported to be conflicting and misleading and was not considered satisfactory.

On Your Own

Middle class women expressed dissatisfaction with the information they received for managing their recovery period at home. They reported that nurses in hospital provided leaflets along with some verbal information. However, they described both of these forms of information as inadequate to meet their needs. They expressed concern that the information lacked detail and a rationale was not provided.

R: "how were you prepared for coming home?"

Sally: "no one seems to tell you very much, no one really says it's because of.... the little pamphlet's fine, but it doesn't really tell you.... you need someone to tell you"

The literature indicates that middle class women are better able to gain information, I wanted to find out if this was so.

Val: "and I said to them haven't you got any leaflets or any information at all?"

R: "was the leaflet helpful?"

Val: "it wasn't a very long leaflet and so that was it. I think it would be useful if they came and talked to you and explained things"

Because of my concern about the use of leaflets as a replacement for verbal advice I wanted to know how useful Val had found it.

As well as requiring more information Sally and Val were expressing a desire to talk to someone about their needs. Verbal as well as written information was sought, not only to clarify the written information, but also to provide opportunity for expression of anxieties and fears.

Kate and Sarah described how they had felt they had to actively seek out information that they felt was otherwise not forthcoming. They were not provided with information prior to their discharge, but had made some effort to find out for themselves.

R: "you said they said take it easy, did they explain any more?"

I expected, partly due to the literature, that middle class women would be more assertive, I wanted to find out if this was so.

Kate: "no, they wouldn't have told me that if I hadn't seen the nurse before I came out. I said to the nurse I'm going home what have I got to do?"

R: "were you clear what you could do when you came home?"

Examining whether Sarah was able to gain the information she required.

Sarah: "basically I had to find information for myself"

Jane also reported that she had used questioning to gain information from the nursing staff. She described how she had been able to seek information for herself, but expressed concern that not all women would do this.

R: "Were you prepared for coming home?"

Finding out how Jane had gained her information

Jane: "I think I was seeking out information being a teacher or whatever but you try and find things out and I think not everybody is like that are they?"

This lack of information regarding the preparation for recovery reflects the findings of Webb's (1986) study of women undergoing hysterectomy. Although previous studies (Davis 1982, Gibbs *et al* 1989a,b, Young & Humphrey 1985) have indicated that leaflets increase patient satisfaction, these middle class women indicated that leaflets did not provide sufficient detail to meet their needs following hysterectomy.

These middle class women also reported dissatisfaction with the information received from nurses in preparation for their discharge. Although the Patients Charter (DOH 1991) states that every patient should have a named nurse, who would in theory provide care from

admission to discharge, none of the women demonstrated an awareness of this when talking of their experience.

The older women, 75 years to 82 years, in this middle class group reported a different experience of preparation for recovery. They expressed satisfaction with the written information they received and demonstrated a similar attitude to the working class women in that they reported how useful it was to have a set of rules which they could follow.

<i>R: "you found it useful (a leaflet)?"</i>	Traditionally older people are considered more
<i>Lucy: " I studied it all that much</i>	compliant with a respect for authority I wanted
<i>more when I came home, from week</i>	to check out how Lucy had used the
<i>to week sort of thing, from day to</i>	information she was given.
<i>day..... I've done everything it</i>	
<i>says here "</i>	

<i>R: "how have you managed at</i>	
<i>home?"</i>	
<i>Laura: "I have done everything they</i>	
<i>told me, everything in the booklet</i>	
<i>they gave me, yes"</i>	

<i>R: "did you know what you could do</i>	Vera was the third older lady I interviewed and
<i>when you came home?"</i>	I wanted to know if she demonstrated a similar
<i>Vera: "it's all on the paper, I just</i>	compliance
<i>followed the instructions and it was</i>	
<i>alright"</i>	

These older women, then, were satisfied with the written information they were provided and demonstrated a desire to comply with instructions in order to enhance their recovery. They, like the women in the working class group, accepted a passive role in terms of their health care. A sense of responsibility and appropriate behaviour in illness has been linked

to age. Williams's (1990) interviews with elderly men and women demonstrated their belief that constitutional strength was linked to a sense of will and responsibility.

The combination of early discharge, lack of information and lack of support following discharge left women feeling vulnerable. While Sally and Val had implied a desire to talk to someone when discussing their need for information, Val raised this again when she talked of the circumstances of her discharge from hospital. She described how she was discharged in a rush and this left her feeling there was a lack of support post-operatively.

R: "how did you feel?"

Val seemed upset when she talked about

Val: " they went and dug out a leaflet, they gave me that and then it was just bye bye "

her discharge from hospital I wanted to know why.

Sarah was discharged only forty-eight hours following her surgery and she described how she felt isolated and lacked someone to talk to.

Sarah: "all strange things go through your head"

R: "did you talk to anyone?"

As she described her feelings when she left hospital Sarah sounded distressed, I wanted to know had she been given the opportunity to talk about her fears, did the nurses recognise her concern?

Sarah: "no, no one, well I had it done on the Thursday and I was home on the Saturday"

R: "that wasn't long"

Sarah: "no, they wanted the bed it's like you've had it done and you're out the door, no one came and said do you want to talk to anyone, you felt you were just on your own"

Jean also described how she felt that there was a lack of opportunity to talk to health professionals. Although she was nursed on a gynaecological ward she did not recognise that staff had specialised skills and made the suggestion that there should be a more

specialised area for this type of surgery.

R: "did the nurses on the ward talk to you?"

Jean: "not really no, whether they could get a special unit for when you're going through that I don't know, maybe then they'd understand a bit more"

Jean expressed her concern and her desire to talk about her anxieties, I wanted to know if the nurses had used this opportunity for health education

This lack of support in the form of information and counselling described by these women mirrors previous studies (Webb and Wilson-Barnett 1983, Webb 1986) of women who have undergone hysterectomy. May (1992b) indicates that the mobility of nursing staff disrupts the distribution of nurse's knowledge. Nurses themselves are not always in the position to provide the information that patients require, this is discussed in Chapter 5.

Following early discharge from hospital there is some suggestion that support is needed when women are feeling on their own and experiencing doubts about how to deal with recovery. Tilley *et al* (1987) suggests patients may be unable to deal with information that addresses concerns they have at home. These women expressed a need not just for information for recovery, but also for an opportunity to talk and discuss their anxieties.

Conclusion

Middle class women expressed dissatisfaction with the information they received in hospital for their recovery. They described the leaflets that were provided as useful, but limited in that they lacked specific information and did not provide rationale for the advice provided. They indicated that the provision of written advice did not provide opportunity for discussion.

Older middle class women presented a different perspective, in a similar way that they did when discussing their surgery and decision making. They, like the working class women, expressed satisfaction with the written material with which they were provided and they

expressed an eagerness to comply with the prescribed regime. They also demonstrated an acceptance of the passive role of the patient .

Middle class women described how they had obtained information for themselves but still expressed concern that they felt a lack of support from health professionals. Despite promises in the Patient's Charter (DOH 1991) that a named nurse would provide care from admission to discharge, there was no indication that this had occurred when middle class women described their experience of hospital. Following early discharge from hospital women described how they felt they were 'on their own' and lacked the information and opportunity to discuss their anxieties and concerns. They indicated a need for a more active part in their recovery than using written material as a guide.

Table 6 illustrates the contrast between levels of satisfaction with written forms of information. Working class women tend to find leaflets and pamphlets useful aids while they are described as insufficient by middle class women. Perhaps more importantly the Table 6 illustrates the lack of satisfaction women of both classes demonstrate with the information for recovery provided by nursing staff.

SOURCES OF INFORMATION FOR RECOVERY			
	SOURCE OF INFORMATION	EXAMPLES OF SATISFACTION	EXAMPLES OF DISSATISFACTION
Working class women	leaflets	Chris: the leaflet was actually quite a good guide Babs: I treated it as a bible Jill: my leaflet was very useful	
	nurses		Debra: they don't really discuss it Ellen: she gave a very, very brief chat Brenda: they tell you to take it easy, not enough really
Middle class women	leaflets		Sally: the pamphlet doesn't really tell you Val: it wasn't a very long leaflet
	nurses		Sarah: I had to find out for myself Jane: I was seeking out information Jean: no-one talked to me

Table 6

PAGE

NUMBERING

AS ORIGINAL

CHAPTER FOUR

ANALYSIS - PHASE 2

NURSES AND DOCTORS VIEWS ON INFORMATIONAL NEEDS OF WOMEN

Introduction

This section of data analysis aims to provide a background to the study. Themes identified in this part of the analysis arose from the questions posed in the semi-structured interviews (see Appendix 5 and 6). The questions were based on the themes which emerged from the analysis of the interviews with the sample of women.

All of the nurses interviewed were female. Three of the doctors interviewed were female and one was male. In the report all will be described as female to protect anonymity.

Preparation for Surgery

Nurses described their role to include the provision of information for women undergoing surgery. They discussed the need to provide information about pre- and post-operative care. In this they included such things as starvation for theatre, the presence of drips, drains and sutures following surgery, relief of pain and wound healing.

Doctors also indicated that they would talk to women about the mechanics of admission to hospital, the need for a general anaesthetic and the length of time women could expect to be in hospital. They reported that they provided this procedural information during consultations in the out-patient department.

Both doctors and nurses indicated that they believed it necessary to provide women with an explanation of the operation. Doctors reported that this would include information about

the part/s of the body to be removed and the consequences of doing this. They also described the need to use terms that women would understand. They acknowledged the use of medical jargon as inappropriate and described how they tried to use terms that were meaningful to all women. (D1): *"I don't tend to assume that all women know what uterus means."*

Nurses reported that women needed to be informed of the details of their surgery. They, like the doctors, indicated the need to explain what a hysterectomy entailed in terms of what organs would be removed. Emphasis was given to anatomical facts rather than physiological or psychological effects.

Doctors and nurses, then, indicated that their roles included the provision of information about the surgery women are to undergo and procedural information. Both groups of health professionals described the explanation of the surgery in terms of what organs are to be removed and less emphasis was given to the significance of this and related health issues.

Decisions About Surgery

Doctors indicated their belief that it is ultimately the woman's choice whether or not to undergo hysterectomy. They reported that they saw their role as providing women with explanations of the options available to them, and that it was then the woman's decision as to whether or not to opt for hysterectomy.

(D1) indicated that she would also give some feeling as to her own opinion of what was an appropriate choice. She felt that her role as the doctor involved giving women some indication of what she felt was the most appropriate form of treatment (D1): *"give her some feeling of what I think might be the best of the options"*.

Doctors indicated that it was also a woman's decision whether or not to have her ovaries

removed at the time of hysterectomy. They reported that if women were post-menopausal they would advise them to have their ovaries removed thus preventing the risk of ovarian cancer at a later date, but if a woman was in her late forties or younger then their advice would generally be to retain the ovaries which are still producing hormones that are very important to women's health. They reported that they presented the advantages and disadvantages and that they believed most women then made their own decision.

(D3) and (D2) added that they believed some women preferred to have the decisions made for them. (D3): *"patients do say 'what would you say doctor?'"*. (D2): *"there are some patients that say 'it's up to you doctor, whatever you think best'"*. However, they demonstrated a reluctance to identify any particular characteristics of these women.

(D1) expressed concern that removal of the ovaries was a difficult area and somewhat controversial amongst gynaecologists. She believed that different gynaecologists would provide differing opinions depending upon the type of practice they see.

Nurses also reported that they believed it was a woman's decision whether or not her ovaries should be removed at the time of hysterectomy. But, they did not acknowledge that they had any real role in this decision making. They described it as an issue between the doctor and the patient. This may be partly due to the fact that this discussion would usually take place in the out-patient clinic prior to admission to hospital and the ward nurses would not usually be involved.

(N7), however, did express the view that nurses should involve themselves with providing women with information for decision making regarding the extent of their surgery. She described how discussion at the pre-admission clinic could provide opportunity for women to gain information and participate in the decisions to be made about their operation. She indicated that if women did not attend the pre-admission clinic then there often was not time for this type of discussion when they were admitted to the ward. (N7): *"sometimes the day before there is not a lot of time to go into some of these things, but at the pre-admission clinic I would definitely discuss things like that"*.

Both groups of health professionals indicated a belief that a woman should ultimately make her own decision whether or not to opt for hysterectomy, and should also have the choice as to whether her ovaries are removed. They described the use of an educational model to facilitate informed choice. However, Rawson (1991) notes that freedom of choice does not always follow from this model. Tones and Tilford (1994) are critical of the educational model of decision making and claim that more is involved than the provision of information. They believe it is also necessary to assure a thorough understanding of relevant issues and clarification of beliefs and values. There is, therefore, a need to provide specific decision making skills.

Doctors saw their role as providing the information necessary for women to be able to make an informed decision. Nurses indicated less involvement with this aspect of information giving, and largely considered it to be an issue between the doctor and the woman concerned.

Information for Recovery

Much emphasis was given by nurses to the need to provide women with information regarding their recovery on discharge from hospital. Both physical and emotional aspects were described when they talked about this aspect of information giving. The practical issues they included were resting, looking after themselves, lifting, going out, returning to work, driving and sexual activity. Emotional aspects were described as warnings about 'getting the blues' and feeling 'emotionally upside down'. These issues were described with no particular emphasis being given to any one of them. Sexual activity is often considered to be a major concern for women undergoing this type of surgery. However, in this study concern regarding sexual issues was not given any particular recognition, either by the nurses, or the women themselves.

They reported that when women asked for specific information about moving stretching and lifting, they found it useful to talk to women about what they described as 'listening to

the body'. (N1): "*they will get to know their own body*". (N7): "*your body will tell you*". When asked just what they meant by these terms they explained that it was a warning to stop if an activity causes pain. (N7): "*when it hurts, stop*".

Doctors also indicated that they would provide information for women for dealing with their recovery. They, however, gave this less emphasis than the nurses and this is possibly partly due to the fact that the main communication between the doctor and patient takes place in the out patient clinic many weeks prior to surgery and at this time the priority is the type of treatment the women is going to opt for. They did, though, indicate that it is necessary to ensure that women understand the need for convalescence and to ensure that there is support at home.

HRT

Doctors reported that the choice whether or not to take HRT was a decision for a woman to make herself. Though for women under forty, they did indicate that they would very strongly advise it. They reported that women needed to know both the short and long term benefits plus the short and long term risks. In this they included the risk of breast cancer, though they described this as inconclusive and negligible.

They appeared overwhelmingly in favour of prescribing HRT to women that had undergone bilateral oophorectomy. (D1): "*the bottom line is that HRT improves life expectancy and quality of life*". (D3): "*I would advise it to all women*". (D2) was less enthusiastic and described herself as neither pro- nor anti-HRT.

Nurses felt there was a need to provide information for women who may opt to take HRT, but they indicated that it was sometimes a matter better dealt with by the woman's GP, this will be discussed later in this chapter. When providing information about HRT the focus was on the types of HRT that are available and nurses gave little emphasis to the need to provide information about the advantages and disadvantages of HRT.

In conclusion, health professionals seem to advocate the use of HRT particularly for those women who have undergone bilateral oophorectomy. They do, however, suggest that it is ultimately the women's choice. The information provided is described as largely being pro HRT.

Who Provides Information

Doctors expressed the view that it was primarily their responsibility to provide an explanation of the surgery, but that there was also a role for the nurse in providing this sort of information. They reported that the out patient's clinic, where this information is usually imparted, is invariably rushed and, therefore, there was a need for a nurse to re-enforce the explanation provided by the surgeon.

They indicated an understanding that women did not always comprehend the information they were given and this could be rectified by the nurse being available for this purpose. (D2): *"they can tell the nurse they had no idea what I was talking about"*. (D1): *"the nurses need to clarify what the doctor said or some of them clear up the mess the doctor's created in frightening the woman"*.

Doctors also expressed the view that patients may find it easier to relate to a nurse. This may be because of either a gender issue or because patients generally feel more at ease with nurses than with doctors. (D3): *"it is still the case that most patients feel more comfortable talking to a nurse than to a doctor"*.

(D1), however, expressed concern that if the nurse adopted this role she had the responsibility of acquiring the necessary knowledge and that she should maintain the same standpoint as the doctor. (D1): *"I've seen that happening you know, 'has that doctor told you to have your ovaries taken out? Oh my god they call him the butcher round here'. You've got to have someone who is in sympathy with what you're saying"*

Nurses reported that patients needed further explanation about their surgery following their explanation from the surgeon. They indicated that reasons for a need to reinforce the explanation of their surgery were varied (N8): "*patients feel more at home with the nurse*". (N4): "*patients feel intimidated by the doctor*". The use of medical jargon was also put forward as a hindrance to communication between doctor and patient. Nurses indicated that they believed it was part of their role to re-enforce women's understanding of their surgery.

Nurses expressed the view that part of their role was to impart health education information to patients. The most positive reports about this aspect of their role was reported to be the part that they played in the pre-admission clinic or support group. Here, they identified that they had a clear role in giving information to patients plus the opportunity to respond to questions that women asked. Nurses identified these clinics as a formal time for exchange of information. In one centre nurses referred to a support group rather than a pre-admission clinic. However, it appeared this served a similar function in that the women that attended did so prior to their surgery and little use was made of it as a support group post-operatively.

In the ward situation (N3) expressed concern that nurses don't actually provide all the information that patients need. She reported that information-giving was not given high priority on a busy ward that was often short staffed. She said (N3): "*we probably should fit it in but we don't seem to*". This particular nurse was a junior member of staff and believed she still had an objective view of the reality of the situation.

Nurses described the use of leaflets or booklets when they talked about the provision of information. Leaflets were described as useful but they also felt that there was a need to talk to women and answer any questions that arose. However, it was of note that nurses described the leaflets as a basis for discussion or questions, and that this indicated that the leaflet may be the woman's primary source of information, followed up by discussion if necessary. Nurses did not describe the leaflet as a back-up or aid to the information that they provided.

When talking about HRT nurses agreed that it was their role to provide information about HRT if it was required. However, they expressed concern that they felt ill-equipped to do this. They indicated concern about their own lack of knowledge in this area and were worried about the accuracy of the information they could provide (N1): *“I could do more if I learnt myself”*. (N3): *“I would like to be able to talk about HRT but I don't know much about it”*. Nurses dealt with this situation by recommending that women visited their GP for information regarding HRT. They did not indicate that the gynaecologist might have had a role here.

Nurses indicated an eagerness to recommend HRT and reported that when they talked to patients about HRT, they saw their role as reassuring them about its benefits. However, (N3) described the need to provide a balanced discussion and expressed concern that doctors presented a one sided view, tending to persuade women to commence HRT: (N3): *“most doctors think it's great to get everyone on it”*.

Though doctors accept primary responsibility for providing explanation of the surgery women are to undergo both doctors and nurses see the nurse as providing a back-up role. It is acknowledged that women do not always comprehend the explanation provided by the doctor and both groups of health professionals indicate that women may be more at ease when receiving information from the nurse.

For nurses the pre-admission clinic is acknowledged as the place where most information-giving takes place. On a busy ward the provision of information may not be given priority, but in the pre-admission clinic the role of the nurse as provider of information is more clearly defined and time is allocated for this purpose.

It appears less clear who is responsible for providing information regarding HRT. Nurses indicated a gap in their own knowledge, and it was reported to be a topic which is often dealt with by GPs when women have left hospital.

Differing Needs

Nurses indicated that different groups of women had differing informational needs. They did, however, describe these in different ways. They referred to the needs of women of different cultural backgrounds and indicated the significance of culture when it came to talking to relatives. Nurses expressed concern that women's cultural background might affect what the woman wanted her partner to know about her surgery. While for women of a different background it may mean her husband talking for her.

Nurses also referred to the age-group of women when reporting differing needs. They indicated that older women expressed less anxiety about the surgery than younger women. (N8): *“at sixty five or over they are not really worried about it”*. They reported that as well as the surgery possibly having less significance than it does for a younger woman, having less responsibility at home in terms of childcare could effect older women's attitudes. They reported that younger women asked more questions and were more assertive than older women. They indicated a belief that this was partly driven by need, but was also a result of attitude to the health service. (N4): *“the older ones feel it's not their place to ask questions.....they'll just take the advice of the doctors and nurses”*.

Level of education was described as a determinant for differing informational needs. Women who were described as 'more learned', 'more educated' or 'well read' were reported to have more knowledge and know how to ask questions in order to seek out the information they required. Whereas, less educated women were perceived to be lacking in information and possibly unable to understand the same depth of information. Though (N4) did suggest they have information, but it was information gained from friends rather than books and, therefore, they may be misinformed.

(N4) made a distinction between 'career ladies' and 'housewives'. When talking about HRT she indicated that she believed women with a career would read and make their own decision while women that were housewives would rely on the advice of the doctor. (N4): *“career ladies, they seem to be able to form their own mind.....other types like housewives, they'll just take the advice of the doctor”*

Nurses indicated that they believed women in different social classes had different informational needs. They described middle class women as being more aware than their working class counterparts. In the same way as they described more educated women they described middle class women as having more knowledge and awareness of options open to them.

They described how women presented differing attitudes in their expectations of the health service. Working class women were not regarded as expecting very much whereas middle class women were described as demanding. They also described a class difference in the way that women reacted to surgery. They largely saw middle class women as recovering less quickly and requiring more care than working class women. (N1): *“working class women would get up and go a little bit more easily.....middle class ladies would expect to be pampered”*

It is interesting to note the use of terminology here, the use of the terms 'ladies' and 'women' indicates a common stereotyping of discrimination between the classes. (N6) went a little further into stereotyping in her description. (N6): *“the lower class woman has six kids and is as tough as an old boot.....the upper class woman who's had one child, she'll be unable to cope”*.

Nurses also talked about class differences in terms of the women's social life at home. They indicated that middle class women have time to dwell on matters related to the surgery and its options, whereas working class women are more concerned with procedural matters due to the pressures on their lives at home: (N1): *“for the lower class woman it's probably a bigger deal with regard to how it will affect their lives at home”*. (N3): *“working class women are probably working more....they need information about going back to work etc.”*

Nurses described how they believe working class women to be dependant on health professionals for decision-making. They reported that working class women do not ask questions and actually prefer not to be involved in decision making: (N6): *“some prefer to*

be kept in the dark". (N4): "they more or less say I trust what you say because you are a doctor or a nurse".

When describing the information they provide for women, most of the nurses indicated that they give all women the same information. Although they reported that they recognised that women had differing levels of information and indicated different needs, they maintained that they believed women should all be given the same information. (N1): *"I always give the same information to everyone"*

(N4) did say that she would present the information differently. She described how she would use less medical jargon and present information in a simpler form for less educated or working class women, though she maintained that she would provide the same basic information. (N4): *"the facts should be the same.....but maybe simplify things"*.

Doctors reported some need to present information in different ways. Largely they focussed on education as the issue and reported that some women were able to handle more complex information than others.

The way that they assessed level of education was partly by the woman's response to them and her ability to converse about her condition. (D1): *"some people come and see me and say they've done an Internet search.....obviously the level of discussion that you have with that woman has to be much greater than you have with a woman whose level of biology is much less"*. (D4): *"you have to approach the information you're giving in a slightly different way, if they've never done biology at school everything has to be quite basic"*.

(D2) and (D3) also acknowledged that the occupational background of the woman may have some bearing on the level of discussion. (D3): *"I do find that professional people do already know a bit more about the subject"*. (D2): *"I will make an assumption that if a woman is, say a professional working as a solicitor, I would assume a certain level of knowledge in her"*. They indicated that they would provide all women with basically the same information no matter what their background, though, they did indicate that they

might present the information differently. (D1) and (D4) indicated that the level of information they provided would differ. (D1) felt that better educated patients had a need for more complex discussion while (D4) indicated that she would provide more information for the women whom she considered were less well educated.

Nurses, then, indicated an awareness of women's differing needs according to age, ethnic group and occupation. However, when it comes to providing information they report that they still believe there is a need to provide the same information for all women, though they do suggest that it might be presented differently.

Doctors focussed on education as the major indicator affecting women's informational needs, though they acknowledged that this might be linked to occupation. They gave greater emphasis to educational background and knowledge of biology. Like nurses, the doctors maintained that despite differences in women's backgrounds there was still a need to provide the same basic information, though the presentation and terminology may differ.

Assessing Class Position

Doctors indicated that though they believed occupation was the official method of documenting social class, they also took other factors into account. They reported that they based their assumptions on appearance, dress, speech and ability to communicate. One of the surgeons also indicated that she would partly base her judgement on what patients told her (D1): *“if they've told me they watched an excellent documentary on channel four last night, that probably forms people's views to be honest”*.

However, (D4) was adamant that social class no longer exists and certainly has little relevance where medicine is concerned. (D4): *“medicine is working away from that, it has been a problem in the past.....it's a long time since somebody has asked me about that (laughter). Really, I think really it's just old hat”*. She indicated that she did not see people in terms of social class and could not, therefore, make any description of how the social

class of an individual might be identified (D4): *“well I don't have to think about it, it's none of my business”*.

Nurses indicated that common stereotypes led them to make assumptions about an individual's class position. They reported common indicators of class position as being appearance, dress, accent and level of articulation. They also reported that attitude to family life and the area a person lived in would give some indication of their class position. Nurses also felt that level of education was significant and they judged this by the type of questions women asked as well as their ability to understand information.

(N2) reported that the assessment of social class was more difficult when women were from minority ethnic groups. She indicated that it maybe that their ethnic background was more significant than their class position when providing information for them and their families.

When assessing an individual's class position, doctors focussed on education. Though they acknowledged such factors as speech and dress they indicated that education, with particular emphasis on knowledge of biology, is the indicator which affects communication. Nurses considered other indicators to be significant, they also talked about the influence of education but demonstrated an awareness of family, geography and lifestyle. This may reflect their education in which there is more emphasis given to social sciences than in medical training. Also, the assessment that nurses make of patients is moving towards a more holistic approach in which the patient's background and social circumstances is given consideration as well as their medical diagnosis.

Conclusion

Both doctors and nurses perceive that part of their role includes the provision of health education information. Doctors focus largely on the technicalities of the surgery and the decision making and procedural aspects that accompany this. They do, however, acknowledge that patients do not always comprehend the information they are given by

doctors and see the nurse as playing a significant role in proving back-up information. The point is made that this should, however, conform with the information that is provided by the doctor and they do not see the nurse as proving information that is contrary to any advice given by the doctor.

Nurses tend to focus on information for recovery, which usually takes place in the pre-admission clinic and while the patient is in hospital. This is also covered briefly by doctors but this may be in out-patients, sometimes before the patient is admitted to hospital. Nurses indicated that they used leaflets and subsequently answered women's queries rather than using leaflets as aids to verbal information.

Both groups of health professionals indicated an awareness that different women had differing informational needs. Doctors believed this was due to educational background and assessed this by the way that women conversed with them. Nurses acknowledged other differences and reported that age, and ethnicity also had a bearing on women's needs.

In the assessment of social class, doctors again relied on education and, though they perceived that these could be linked to occupation, they indicated that education was the most significant factor. Nurses also reported education to be a factor in the assessment of class position but also talked about the area where a person lived, the attitude to their family and their general appearance and mannerisms as being significant.

Although both groups of health professionals acknowledged individual differences, and were able to describe some way of recognising these, they indicated a belief that all women should be given the same information. They reported that the information may need to be presented in different ways, but maintained that the same basic information should be provided.

CHAPTER FIVE

SYNTHESIS AND CONCLUSION

Explanation and Decision Making

When undergoing hysterectomy for a benign cause women may just have the uterus removed or, the uterus along with the fallopian tubes and ovaries. Women talked about their understanding of their surgery and about their contribution to decisions regarding the extent of their operation

Women at the lower end of the social class gradient used medical jargon when they talked about their surgery but demonstrated a lack of understanding of what the terms actually meant, suggesting a lack of power in their relationship with doctors. Although they indicated little knowledge of their surgery and its consequences they reported that they were satisfied with the information they received. They demonstrated an acceptance of a passive role in their consultation with doctors and displayed deference to the medical profession.

In contrast, middle class women expressed dissatisfaction with the information they received regarding their surgery. They demonstrated understanding of their operation but were not happy with the sort of explanations they had received from doctors. They had greater expectations of receiving information than their working class counterparts and expressed disappointment when their needs were not met. When they described their understanding of their surgery they focussed on anatomical facts rather than the implications in terms of health gains and losses. Health professionals also reported an emphasis on the anatomy with use of diagrams to explain the operation. There appears to be a tendency for them to focus on biological concepts over which they have knowledge

and control.

Doctors expressed the view that it was primarily their responsibility to provide information about the nature of the surgery but they also saw a role for the nurse in providing supplementary explanation and information. Nurses agreed with this in principle, but could only recall having the opportunity to do this when women attended a pre-admission clinic and there was a formal time allocated to the exchange of information. Women did not refer to nurses in any way when talking about the explanations they received regarding their operation and gave no indication that they saw this as part of a nurse's role.

When it came to decision making as to the extent of their surgery working class women did not demonstrate any desire to be involved in decision making and indicated that they preferred the doctor to adopt a paternalistic role (Stewart and Roter 1989). They appeared to derive comfort from their reliance on the doctor and portrayed the notion that decisions about their body should be made by experts.

Middle class women demonstrated a desire to take a more active role in decision making. They described situations where as patients they took an active role but felt that the gynaecologist acceded to their request rather than participating in discussion. Doctors appear to be letting women take the role of consumer as described by Stewart and Roter (1989) rather than entering into a relationship of mutuality in which there is frank discussion of the facts required to facilitate decision making.

For middle class women an inappropriate manner of communication and lack of time in consultations led to frustration. The term 'on a conveyor belt' was used to indicate their feeling of lack of worth when there was not adequate time for explanation and discussion. An inappropriate choice of place and time for providing information was also cited as a problem. Last minute discussion about the nature of the surgery left women feeling a lack of power in the decision-making process and confirms the patriarchal nature of the medical consultation even for women from a middle class background.

Both middle and working class women described how discussion about the removal of their ovaries took place when they arrived in the operating suite. Approaching the topic at this stage left little real opportunity for discussion and confirms the patriarchal stance of the medical profession over women. The reactions of the women concerned varied according to their class position. Brenda, at the lower end of the social class gradient, expressed little concern about the situation. She made the assumption that there was little to discuss as the doctor with his knowledge and power was best equipped to make decisions about her body. Whereas Sally, who is middle class, described how she found the incident frightening and reported that she would have liked to participate in an earlier discussion.

Although recent health care reforms have encouraged NHS patients to think of themselves as consumers there seems little to indicate that these women have had the opportunity to do so. The consumerist approach to health care depends upon the patient having bargaining power, freedom of choice and the knowledge and power to challenge medical authority (Lupton *et al* 1991). For working class women this appears to be a long way off and though middle class women indicated a desire to play an active role in their consultation with the doctor they reported that a lack of symmetry in the relationship prevented them from doing so.

Those women who did report making their own decision did so without discussion with the doctor. They largely gained their advice from friends and relatives and indicated that the gynaecologist merely accepted their decision without discussion, but, they neither expressed dissatisfaction with this situation nor had expectation of receiving information or advice from the doctor.

Nurses and doctors indicated that they believed all women should be provided with information regarding their surgery and be involved in the decision making process. Doctors indicated that they saw themselves as providers of information to facilitate this process. They described an educational model of health education in which information is provided and the individual then makes a decision. This is, however, a simplistic notion and Tones and Tilford (1994) are critical of this model claiming that it must be acknowledged

that the notion of free choice is curtailed by moral imperatives. Freedom of choice requires knowledge which can be gained, but, also freedom of choice may be constrained by individual limitations, social networks or unequal power relationships. Decision making skills acquired by activities such as role play are also essential if the individual is genuinely expected to participate in the process (Tones and Tilford 1994).

Nurses indicated little involvement with the decision-making process. Though they believed they had a role in clarifying information about the surgery they reported that there was not always opportunity for this and they did not describe their role as facilitating decision-making. Neither did the women have any expectation of gaining this sort of information from the nursing staff. When they talked about their experience of receiving information about their surgery they referred only to the doctor and when asked if the nurse might have a role here they responded negatively.

When health professionals talked about the sort of information they provided they indicated that it was necessary to provide all women with the same information. Though they did report that they may use different expressions or terms in their presentation, they believed that all women had the same needs. It seems they based their model on one of equality in the provision of information rather than one of equity in terms of identifying individual needs. It was not acknowledged that some women, ie. those from the working classes or with less education, may have greater need for information and certainly would require some assistance with decision making skills as identified by Tones and Tilford (1994).

Doctors felt that women's class position had less relevance than education when deciding the level of discussion. Although they report giving the same information to all women it was suggested that the level of discussion may be more complex if the patient was more educated. This sort of decision was made by assessing the way that the woman conversed with the doctor when she came to clinic. Nurses also indicated that they provided basically the same information for all women and they reported the class differences to be more significant in terms of how the women respond to the illness. Working class women were considered to be tougher and more likely to make a quicker recovery whereas middle class

women may require more pampering.

Although nurses identified themselves as having a role in health education they appeared to support the patriarchal stance of their medical colleagues, though this may not have been intentional. They did not identify themselves as having a role in supporting women through the decision-making process and though they use the pre-admission clinic to impart health education information about surgery, there is little evidence that this information is provided whilst women are patients in hospital. Medical authority may well prevent nurses from involving themselves in decision-making about patients surgery. There was some indication of this by the doctor who, although he acknowledged how nurses could usefully participate in this process, was anxious that they should only do so if they were in agreement with the surgeon. May (1992b) argues that nurses may be restricted from playing an active role because they are subject to both medical authority and bureaucratic rules.

Older women in the age range seventy-five to eighty-two years in this middle class group of women expressed quite different views. They, in a similar way to the working class sample, were satisfied with the information they received about their surgery even though this was minimal. They did not expect to be involved in discussion about the nature of their surgery and described the paternalistic relationship with the doctor as satisfactory.

Conclusion

Although there is little difference, then, in the quantity and quality of information provided about the nature of the surgery given to women from different class backgrounds, the level of satisfaction with this information does vary according to class position. Nurses and doctors report that they provide the same information for all women but it is evident from reports of the women themselves that they do have differing needs.

Working class women have been socialised to expect an asymmetrical relationship with

their doctor. They accept a passive role and express satisfaction and gratitude for minimal amounts of information. They demonstrate an acceptance of lack of control over their own bodies in medical matters and place it in the hands of doctors who they perceive as having knowledge and power. In contrast, middle class women demonstrate expectations of an active role as patients in their medical consultations. They report, to some extent, having taken on the role of consumers and expect involvement and choice in health care.

Women expected explanations of surgery and information for decision making to be provided by doctors rather than nurses. Health professionals held similar views. Nurses identify a role in providing this sort of health education information but feel that they have little opportunity to perform this role. Nurses could see a role for themselves but it seems that they actually play little part in clarifying explanations of surgery and in facilitating decision making and patients certainly have no expectation that they should do so.

Information for Recovery

Following discharge from hospital approximately five days after surgery, women spend a period of ten to twelve weeks recovering at home. During this time they make a gradual return to normal activity.

Working class women expressed dissatisfaction with the information they received for dealing with their recovery. Though they expected explanation of their surgery from the doctor they looked to the nurse to provide them with help to manage their recovery. However, they described leaflets as their main source of information and, though these were described as useful, they lacked some of the specific information that was required.

Middle class women also expressed dissatisfaction with the information they received about managing their recovery. They expected nurses to provide them with detailed information with which to manage their recovery. But they found that the information they received was vague and that they also felt there was a reliance on the use of leaflets which were

described as lacking in detail and rationale.

When talking about their experience of recovery working class women indicated that they used the health education leaflet as a set of rules to which they rigidly adhered. Their rigid compliance demonstrates their attempt to conform with treatment in the hope of getting well, emphasising their asymmetrical relationship with health professionals. It demonstrated an acceptance of the sick role (Parsons 1951), emphasising further the passive role they accepted as patients.

The need for more specific information to manage recovery reflected past studies (Webb 1986, Bernhard 1992) of women undergoing hysterectomy which indicated that information consisted of vague generalisations. Although nurses also stressed the importance of providing information for recovery, they did not identify a need to provide specific information. They talked about advising women to listen to their own body as a way of judging what activities to undertake. Nurses indicated a belief that women required information about both the physical and emotional aspects of their recovery. Doctors gave this aspect of information less emphasis than nurses, but indicated that women did need to be prepared for coping at home as there was a need to ensure that support was available.

Middle class women felt that to gain some of the information they wanted from nursing staff they had to actively question them otherwise the information was not forthcoming. Women at the lower end of the social class gradient were, however, very reluctant to display what might be thought of as criticism of nurses. They were anxious to praise them and blamed the lack of opportunity for discussion on an over-stretched health service. It can be questioned where this image comes from. No doubt the media convey a message of overworked health professionals but do nurses also portray a role of nursing that has an emphasis on the provision of physical care and being actively busy. The provision of information and discussion with patients maybe given less priority than the provision of physical care

Though the women from working class backgrounds expressed reluctance to question

health professionals, perhaps because of their perception of the 'busy nurse', they did deal with their deficit in information by turning to friends and relatives. This was, however, described as unsatisfactory as it was recognised that information from these sources could be conflicting and misleading. Nurses also recognised this as a problem and described how working class women maybe misinformed because of their reliance on inappropriate sources of information.

Middle class women indicated a need for someone to talk to about their anxieties. Their concerns were less about procedural matters and focussed more on the feeling of isolation and the need to have someone knowledgeable to talk to. There was a lack of recognition of nurses specialised gynaecological knowledge. Though many of the nurses on the gynaecological wards had undertaken specialised courses in gynaecology or women's health this was not recognised by the women they nursed. Are nurses lacking in confidence to impart information to women or is it again that the emphasis in the role of the nurse is to be busy with more physical tasks which must always take priority?

Though nurses indicated that they saw health education as part of their role they very much described the pre-admission clinic as a place for information giving, when time was set aside for this purpose. Nurses identified these clinics as a formal time for exchange of information while, in the ward setting, information giving was not described as a priority particularly when busy or short staffed.

Nurses indicated a belief that working class women are more in need of procedural information in order to manage their busy lives. However, they still described the use of leaflets as the primary source of information for women rather than a support for verbal information which is what women indicated that they require.

The older women in this middle class sample again reported a different experience. They were satisfied with the written information they received and demonstrated a desire to comply to the what they described as the instructions they were given. In a similar way to the working class women these older ladies demonstrated an acceptance of the sick role

(Parsons 1951). A sense of responsibility and desire to display what is believed to be appropriate conforming behaviour has been linked to increasing age (Williams 1990).

In conclusion women from both class backgrounds felt that they were poorly prepared for discharge from hospital. Nurses indicated their belief that provision of this aspect of health education information is an important part of their role, but evidence from the women's accounts indicates that nurses tend to rely on informational leaflets and neglect verbal information and discussion.

Middle class women described leaflets as lacking in the specific detail and rationale that they required but that they were a useful aid. Working class women used the leaflets as a set of rules to be adhered to thus indicating again their adoption of the sick role (Parsons 1951) and acceptance of passivity as patients.

Middle class women were able to gain information by questioning nurses but working class women reported a reluctance to do so and described nurses as too busy to deal with this aspect of care. They turned to friends and relatives and as a result described themselves as sometimes confused or misinformed. Nurses recognised that this happens and is a cause of concern.

Although the Patients Charter (DOH1991) states that every patient should have a named nurse to provide care from admission to discharge none of the women made reference to an awareness of this concept. They were unable to identify a nurse who had taken responsibility for preparing them to go home.

Information for Menopause and HRT

Many women who have undergone hysterectomy are prescribed HRT either because they have had their ovaries removed or because they have reached an age where the ovaries have ceased to function and oestrogen replacement therapy is seen as useful. Therefore the

issue of HRT was discussed by many of the women in the study and it became apparent there was a deficit in the information available.

Working class women indicated that they had gained information about HRT from the nurses in hospital. However, it was evident from their discussion that the information they felt they had received was in fact advise to take HRT. Although the nurses felt that women needed information and should be able to make their own decision as to whether to take HRT, they did not always see themselves in a position to provide this information. This was because of their own lack of knowledge, and they expressed some concern about this.

Middle class women expressed dissatisfaction with the information they received regarding ovarian function and HRT. They demonstrated a desire to take an active role as patient but felt that they were unable to do so because the information they required from health professionals was not forthcoming. Medical staff adopted a paternalistic approach (Stewart and Roter 1989) to the prescription of HRT, and middle class women felt that they lacked power to make their own decisions.

The adoption of the sick role (Parsons 1951) was once more demonstrated in the way that working class women accepted their prescriptions for HRT and did their best to conform by taking the medication. However, their understanding of why they should take it was limited. They described their prescription for HRT as something which was essential and demonstrated little understanding that it was, in fact, an option at their age. They indicated powerlessness in accepting HRT as a matter of course with no acknowledgement that it was a matter of weighing up the advantages and disadvantages.

Middle class women reported that they were prescribed HRT without consultation in the same way as working class women. They expressed dissatisfaction with being prescribed a drug when they felt that they were unclear about its benefits and its side effects. Although they had access to leaflets they reported that they had been given prescriptions for HRT without discussion about the medication with the health professionals. For one woman her way of dealing with this was to accept the prescription but to then not use it and seek her

own remedies from a health care shop. Indicating, thus, that even for a member of the middle classes it is perhaps easier to present oneself as conforming patient.

Past studies have indicated that most women gain their knowledge of HRT from the mass media and GPs and this appears to be reflected in these findings. Although nurses recognise that women require this information they have some apprehension in taking an educative approach because they feel they lack the necessary up to date knowledge. This seems to lead nurses to adopt the patriarchal role of their medical colleagues as many of the women perceive nurses to be recommending the use of HRT.

Doctors expressed the notion that women have the right to make their own decision as to commencing HRT but indicated that they themselves were very pro HRT and that the underlying feeling was that they felt it was advisable for women to take it. However, from reports of the women it seems that few of them remember having any discussion about HRT with their gynaecologists. Most of them have seen their GPs, and indeed this is what the nurses reported they recommended, as they feel they lack the knowledge to deal with it in hospital.

For middle class women the choice to take HRT was based on long term health gains rather than symptom relief. They expressed concern about the prevention of osteoporosis and heart disease. Those who chose not to take HRT did so because of the perceived risk of breast cancer. It is of note that the information of these risks was gained largely from the media. Whilst gynaecologists perceive this risk is minimal for women not in 'at risk' groups, they are in fact failing to get this information across to women who are wanting to actively make their own decisions.

Working class women described their reason for taking HRT to be for the relief of uncomfortable symptoms of oestrogen deficiency. This somewhat confirms the prevalence of the medical model of the menopause in which it is viewed as a deficiency condition. Though this 'disease construction' of the menopause may be the only way for women to gain help (Daly1995) it confirms the exertion of professional power in which medication is

automatically prescribed rather than looking at possible alternatives.

Those working class women who chose not to take HRT did so because of a general dislike of taking tablets. They demonstrated a view of health as the absence of illness which fits with past studies of working class women (Blaxter and Paterson 1982). Their dislike of medication is possibly because it is perceived as something for those who are sick. Although HRT is regarded as something which may enhance health this was not acknowledged by these particular women.

Women in hospital who take might HRT because they have had their ovaries removed, or are at an age where they might consider it because ovarian function is declining, are failing to gain the information they require from health professionals.

Though gynaecologists report that they address this issue when they see women initially in the out-patient clinic women indicate that they have little memory of this when it comes to their discharge from hospital. Nurses indicate that they feel unable to deal with this aspect of health education because of their own lack of knowledge.

Working class women deal with this information deficit accepting their passive role and taking their prescription for HRT without question. Middle class women are less happy and although they describe the experience of being prescribed HRT without consultation they are more likely to question what they consider is doctors power over their own body

REFLECTION ON THE METHODOLOGY

Design

This study was designed to meet the aim of gaining the 'emic' perspective, that is the informants definition of an experience. To explore how class position affected a woman's experience of receiving information in hospital I adopted an approach that allowed me to see their world from within, and avoided defining and describing their problems from an etic perspective. The qualitative approach adopted for this study allowed me to focus on the subjective meanings and experiences as described by the women themselves. The themes which emerged from the data indicated that the use of pre-coded, quantitative categories would not have revealed the range of experiences described by the women I interviewed. The construction of social explanations emphasised the complexity of the data rather than providing a survey of surface patterns.

Ethnography influenced the design of this study as it attempts to place the subjects own perspective centrally (Aldred 1998) and enables the researcher to recognise cultural influences on individuals. I wanted to adopt the position of a 'radically naive observer' (Atkinson 1992) and described the experiences of the women from their own perspective.

I anticipated that in-depth interviews would gain authentic understanding of women's experiences from their perspective. Though participant observation is seen by many as synonymous with ethnography (Taylor 1996) I chose not to adopt this method because of the practical difficulties of being present at the time of information giving. Although the process of information giving could be clearly identified as taking place in the out-patient clinic and the

pre-admission clinic it was not possible to identify when this process took place during the hospital stay. I was therefore concerned that to observe just some occasions would not provide me with the rounded insight into the experience the women had of gaining information.

On reflection, however, observation of communication between women and nurses in these clinics may have been a useful addition. The findings indicate that women's consultations with their gynaecologists did play a major part in their experience of gaining information from health professionals and observation of this process may have been valuable. Pre-admission clinics were also identified as a major source of information for women. Observation allows the generation of data in the specific social context in which it occurs, rather than relying on retrospective accounts (Mason 1998). Observation of interactions may have illuminated the roles that women adopted when communicating with health professionals.

The qualitative methodology, then, allowed exploration of experiences that quantitative measurement could not have conveyed. To have tried to specify in advance a range of experiences from which to develop questions, or measure satisfaction and dissatisfaction would have reflected my own thoughts and experiences rather than those of the women I was studying. The use of informal in-depth interviews ensured that the data that emerged reflected the feelings of the women themselves.

Sampling Considerations

The use of three study centres from which to sample both women and health professionals aimed to avoid the peculiarities of one particular hospital practice. It did, though, raise the issue of making comparisons between the centres when analysing the data. It would, however, have been methodologically unsound as the numbers from each centre were relatively small in terms of making comparisons. Any such comparisons were therefore purposely avoided.

Assessing social class has caused some problems. The classification I chose has been useful in

that it is oriented to women, but it is questionable whether it still adequately discriminates between middle and working class. The reallocation of occupations in social classes III_n and III_m more appropriately divides the clerical worker and the shop worker who have different market positions and terms of employment. However, other anomalies remain, particularly the issue of all nurses being allocated to class II whatever their qualification or grade, meaning that a director of nursing services is in the same class as a nursing auxiliary.

The use of three centres, then, was useful and a quota sample of women from working class and middle class backgrounds was obtained with little difficulty. The issue of measuring class, however, remains a difficult one and I would reiterate the need for an empirical classification which accommodates women in all of the working roles.

Interviews

An interview is a social interaction as well as an information gaining activity and the two cannot be separated. It is inappropriate to view this social interaction as a bias which can be eradicated. Instead it is better to explore the complexities of the interaction rather than try to control them (Mason 1998). It was my intention that throughout the interview my interaction with the informant would increase the depth and the breadth of the information I gained.

I therefore had to carefully consider my approach to the interview. I was of a similar age to most of the women I interviewed and like many of them also had a grown- up family. I therefore found we had something in common and this frequently proved a basis for discussion in the warm up period. I had to be aware, however, that I would be viewed by these women as white and middle class, and question whether my relationship would be different to those women who perceived themselves to be of a different class or ethnic background.

In all of the homes I visited, no matter what the class or ethnic background of the woman, I was made to feel welcome and on almost every occasion offered some sort of refreshment. Women talked to me about their families and showed me photos of their grandchildren etc.

This was further compounded when one of the women became upset after expressing how she had been very frightened about her operation following the death of a close friend but had not acknowledged this before, this particular woman was from a working class background.

I felt this reflected the depth of my relationship with the women I interviewed and there is evidence in the data that the information I gained was deeper than superficial responses to questions. On reflecting on the data there is no apparent difference in the depth of information I received from the different groups of women.

From a feminist perspective I had to consider the relationship of hierarchy between myself and the women I interviewed. I recognised that as a researcher I not only had control of the situation but also entered the relationship as a researcher with a professional qualification. I also noted McRobbie's (1982) notion that it may be that women's willingness to talk is an indication of their powerlessness.

I therefore do not believe that the interaction was non-hierarchical and have to acknowledge the influence this may have had on the data. I had to question to what extent women might give me the answers they thought I wanted to hear. In a study of mother's support networks, Bell (1998) questioned whether women viewed her as a researcher and therefore 'public' spectator, raising the issue of how far women attempted to present their lives for her. Did the women I talked to see me as a 'health official' and give me a public account of their experience?

In the early stages of the interviews many of the women did tend to talk in positive terms about their experience of undergoing surgery, though this was not always so. However, as the interview progressed and the informality prompted conversation, women's accounts became more personal. It is of particular note that the women who were not informed of the possible removal of their ovaries until they were in the theatre suite had not sought to stress that aspect of their experience. They had related this as just part of their story and elaboration only came when I explored this issue further. It is evident in the findings that some women were critical of the lack of information they received or the way that they received information and this also

perhaps indicates that women were not solely telling me what they thought might please me.

Although I felt the situation between myself and the informant could not be truly non-hierarchical, I did endeavour to minimise the disruption and inconvenience to women's lives. I carried out the interviews in the informant's own home at their convenience. This sometimes meant the intrusion of televisions, phones ringing and interruptions from other family members. However, I felt that this helped to make the occasion less official and added rather than subtracted to the content of the interaction. On a few occasions, women's husbands were at home and they chose for them to be present. They usually opted for providing the tea or coffee but in one of the early interviews the woman's husband was eager to tell me of his recent experience in the accident and emergency department. Again, I felt that this added to the interview and prompted further information to be revealed by his wife.

Reflecting on the process of the interview I suggest that I did gain women's personal accounts of their experience. The informal, conversational approach to the interview seemed to allow a relationship to develop between us and women appeared to talk freely of their experience. Listening and re-listening to the tapes indicates that women related experiences that they had not had the opportunity to talk about to others. However, it is difficult to deny that hierarchy had a role there and that the very notion of women's powerlessness in the health care setting prompted their desire to talk to me.

Analysis

There is no clear set of conventions for qualitative data analysis. The data needs to be sorted and ordered in some way to be able to make some interpretive sense and build explanations. There are customised computer software programmes available for dealing with qualitative data and these have obvious practical advantages (Miles and Huberman 1994). However, analysing qualitative data is a subjective, interpretive process and there is a danger that this is lost with the use of a software package.

In the early stages of the study I considered, and talked with my supervisor, about the possibility of using a computer programme to assist in the analysis of data. However, I had some apprehension about the use of such a programme and proceeded to analyse the data manually. On reflection I feel this was an appropriate decision. Mauthner and Doucet (1998 p122) state “.....the whole point about data analysis is to learn from and about the data: to learn something new about a question by listening to other people”. The closeness gained by the use of the manual method of analysis gives the researcher a feeling for what the informants have said and Webb (1999) states this leads to a thorough process of analysis.

Morison and Moir (1998) argue that the use of computer software can mask the creative role of the analyst. Where certain words are used to reduce the data there is a danger it may approximate a quantitative approach and this is unacceptable for qualitative research which has a theoretical perspective and is not simply looking for occurrences of similar words (Webb 1999). As a novice to qualitative analysis, therefore, the use of a programme may have reduced the process to content analysis and the intuitive and interpretive elements would have been lost.

Conducting the analysis without the aid of a computer programme, then, I felt added to the interpretation and intuitive process. It was also a learning experience on my part and though there is little doubt that technology can speed up a very timely process it is of value to learn the hard way and save the use of software programmes for some parts of the analysis when experience denotes how it can be used.

To support the analysis, I have used segments of selectively transcribed speech from the tape recordings. However, I was aware that there would be differences in the way women speak which would be highlighted when put into writing. These difference would particularly reflect differences in speech according to social class position as discussed in Chapter 2. Standing (1998), in a study of lone mothers, made a decision to tidy up the language of the women who spoke to her. I had concerns however that in doing this I might lose the powerfulness of speech and I felt that I should record accurately what women said to me.

I also felt that to change women's speech, to modify it to fit with my own style or an academic mode of writing, would reinforce the notion that the speech of women from some class positions or ethnic minority backgrounds is somehow inferior. Whilst I did not want to reinforce what might be considered negative stereotypes, I did want to value all the women I interviewed and not lose their authentic voices.

Conclusion

A qualitative methodology appears to have facilitated the achievement of the overall aim of this study. It has allowed me to gain insight and record women's experiences of receiving health education information. The use of a quantitative tool would not have produced the themes which emerged from the data and reflected the women's own accounts of their experience.

A quota sample of thirty-six women from three different centres enabled me to describe the experiences of women from the different perspectives according to class position. It avoided the risk of findings being due to a peculiarity at one particular centre but did not facilitate a comparison of different centres, however, this was not what I set out to do.

The assessment of women's class position presented problems, the classification adopted was useful but had its limitations and further work is required to appropriately identify women's class position.

In depth, informal interviews allowed me to gain women's accounts of their experiences. My intention was to approach the interviews from a feminist perspective and minimise the hierarchical position between myself and the informants. Oakley (1993) argues that the goal of finding out about people is best achieved when the relationship is non-hierarchical. An informal non-hierarchical approach allowed a relationship to develop in which women talked openly of their experiences. I did, however, feel that the relationship could not be described as wholly non-hierarchical and took on board the notion put forward by McRobbie (1982) that my position as a researcher indicated some sort of hierarchy and that women's willingness to

talk was a reflection of their powerlessness in relationships with professionals.

The manual management of the data without the aid of a computer programme allowed me to learn an intuitive approach to qualitative data analysis. For the researcher experienced in handling qualitative data, computer software undoubtedly has its uses. However, listening and re-listening to tapes and cutting and pasting excerpts of transcripts to search for emerging themes has allowed the analysis of data for this study to be interpretive and not merely a content analysis.

Improvements to Research Strategy

Overall then the strategy adopted for this study has yielded some positive results. Approaching the research from a feminist standpoint and adopting a qualitative methodology has facilitated the emergence of themes which describe women's experiences of receiving health education information from their perspective. However, if embarking on this research again there are inevitably some changes in strategy which may enhance the research.

The study was influenced by ethnography in terms of research design and the methods employed were shaped by Spradley's (1979) format for ethnographic interviews. These in-depth interviews have yielded rich data. However, participant observation is the most commonly employed data collection method in ethnographic studies and, on reflection, I feel this should have had a place in this study.

If it was to be repeated, I would advocate the use of participant observation as a data collection method alongside the in-depth interviews. Whilst, as argued in Chapter 3, it may not be possible to immerse oneself in the culture of the out-patient clinic or the pre-admission clinic, a period of observation may have provided an opportunity to view these events through the eyes of the people being studied and understand the different roles adopted in the particular social context.

Whilst the semi-structure interviews with doctors and nurses have provided a useful background to the study, this data is of limited use. It provides information of the way that these health professionals desire to conduct their practice, but it does not demonstrate the interaction and roles adopted in the particular circumstances.

Phase 2 of the study also presented some difficulties because of the self-selected sample. As discussed in Chapter 3, none of the senior nurses at any of the centres participated in the interviews and none of the doctors at one particular centre took part. Those that did participate may well have been members of staff who particularly valued the importance of information giving. This could of course, not be ruled out even if observation was the chosen data collection method.

Qualitative studies are by definition small scale research and meaningfulness replaces generalisability as the aim of the research. Subjects are selected because they can illuminate the subject under study and a small number are selected because of the large volume of data that must be analysed (Sandelowski 1986). Guba and Lincoln (1981) suggest that the idea of 'fittingness' is more appropriate than the term generalisability. They suggest that a qualitative study whose findings 'fit' contexts outside the current research situation can be described as having 'fittingness'. However, this study could now be further developed by employing a quantitative methodology to assess the prevalence of these findings amongst a larger population of women.

On reflection, then, this study could be improved by comparing different kinds of methods, observation and interview, and different kinds of data, qualitative and quantitative. This sort of comparison is known as triangulation. The term triangulation is derived from navigation, where different bearings give the correct position of an object (Silverman 1994). The multi-method approach reduces the risk of findings being method dependant (Taylor 1996).

IMPLICATIONS OF THE STUDY

Findings of this study suggest that women's informational needs are not wholly met whatever their social class background. Women are not a homogenous group and thus it would seem that health professionals insistence on providing the same information for all is not ideal. Tones and Tilford (1994) suggested goal of equity for health education may mean a more differentiated approach, beginning with acknowledgement that felt needs ought to be taken into account. Also there is a need to guard against the assumption of a homogenous experience in large sections of the community. Equity means assessing women as individuals and catering for their informational needs based on that assessment.

Nurses are in the unique position of spending most time with patients and are, therefore, very well placed to provide health education. Pre-admission clinics successfully provide an opportunity for nurses to formally put aside time for information giving. Both patients and staff describe this service as useful and this concept needs further development. The implementation of a nurse led clinic in the out-patients department could meet the informational needs of women undergoing hysterectomy. A formal meeting with the nurse following their consultation with the doctor could provide opportunity for women to ask questions and clarify understanding and would facilitate the provision of both procedural information and knowledge according to need. It could also provide opportunity for nurses to provide an educative approach to empowerment (Hampson and Hibbard 1996), and those women who have little expectation of taking an active role in their treatment can be encouraged to not only develop knowledge and understanding but also clarify their beliefs and values, thus moving them towards a more active role.

The continuation of pre-admission clinics would allow women to receive information about their hospital stay and their recovery at home. These clinics can also involve the sharing of

queries and problems and can facilitate self-help. This would provide women with more power and control over their own health. However, this can only happen if it is recognised that women's needs for information differ. Treating women equally in terms of the provision of information is not meeting their needs as individuals and this needs to be acknowledged.

Information for dealing with recovery would need to be re-enforced when women are in hospital. Currently, care plans are prepared when women enter hospital but though these focus on physical and psychological problems, health education needs are rarely formally identified. Nurses need to assess information needs and identify deficits on an individual basis which could then be formally documented in the care plan. The concept of the named nurse who is responsible for care from admission to discharge could further be developed to encompass educational needs.

There is a great opportunity for health education when women are in hospital, particularly when they have undergone elective surgery and are expecting to reach a full recovery. This health education could encompass many aspects of lifestyle and in a gynaecological setting should certainly address issues regarding women's health. Women are leaving hospital with an information deficit regarding HRT. This seems to be partly due to the lack of knowledge nurses perceive themselves to have. This needs to be remedied by further education and the presence of current literature and study results in the clinical area. It is a wasted opportunity, in terms of health education, for women not to have gained this knowledge when they have spent a week in a specialist centre for women's health.

Conclusion

It is disturbing that the findings of this study indicate that the information provided by health professionals, when women are undergoing elective surgery, does not meet the needs of either working class or middle class women.

Working class women are satisfied with the information they receive from doctors about their operation and their medication. However, they accept a passive role and relinquish control over their body to the doctor who they perceive to hold all the power and knowledge in health matters. They are less satisfied when it comes to gaining information for dealing with their own recovery. They expect to gain this information from nurses but in reality find that they have to depend upon the use of leaflets. They describe a need for more verbal information, although they are reluctant to question nurses because they perceive them to be too busy to deal with these matters.

Middle class women are not satisfied with the information they receive. They express expectations of a mutualistic relationship with their doctors and are disappointed when this is not the case. They also require more information about the recovery period and express disappointment when this is not forthcoming from nurses. They express a need for an opportunity to discuss their anxieties as well as gaining procedural information.

These findings reflect past studies (Webb and Wilson-Barnett 1983, Webb 1986, Bernhard 1992, Haas and Poretz 1992) which have indicated women's dissatisfaction with the information they received when undergoing hysterectomy. However, these previous studies did not address differences between women from different social backgrounds. This study adds to previous knowledge by identifying the diverse needs of women in different class positions. They have differing expectations of receiving information and they adopt varying roles as patients which affects their relationship with both doctors and nurses.

Patient education needs to be taken on board by health professionals as a necessity rather than a luxury. However, it must be addressed in term of equity rather than treating women as a homogenous group with the same needs. Nurses are in the unique and challenging position of spending most time with the patient and should be taking on board the opportunity for providing health education .

This study also provides material for further research. It would be of interest to employ a quantitative methodology to assess the prevalence of the findings which have emerged from

this research.

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Appendix 1

Middle class sample

Pseudonym	Occupation	School leaving age	Home
Pollie	typist	15	own
Viv	clerical officer	18	own
Kate	clerical officer	16	own
Lucy	clerical officer (retired)	15	own
Eva	local government officer	16	own
Enid	clerical officer	16	own
Jean	clerical officer	15	own
Ivy	receptionist (retired)	15	own
Vera	personnel officer (retired)	15	own
Sally	student (formerly clerk)	16	rents
Alison	clerical officer	17	own
Laura	nursery teacher (retired)	15	own
Vicky	clerical officer	17	rents
Jane	teacher	18	own
Joy	clerical officer	18	own
Val	clerical officer	16	own
Sarah	student - computing	16	rents
Liz	audit clerk	16	rents

Working class sample

Pseudonym	Occupation	School leaving age	Home
Nora	childminder	15	rents
Bev	cleaner	15	rents
Dawn	industrial cleaner	15	rents
Sue	care attendant (retired)	14	own
Ellen	machinist	15	own
Cath	machinist	15	own
Debra	care attendant	16	rents
May	cleaner	15	rents
Jo	care attendant	15	own
Ann	machinist	15	rents
Babs	care attendant	16	own
Helen	machinist	16	own
Pat	shop assistant	15	own
Jill	housekeeper	15	rents
Chris	packer	15	rents
Gail	machinist	18	own
Brenda	shop assistant	15	own
Alice	care attendant	15	rents

Appendix 2

Dear.....

I am a registered nurse undertaking a research study investigating the different experiences that women have of recovery following gynaecological surgery. The findings will assist hospital nurses to plan to meet the health education needs of women in hospital.

For the purposes of this study I would like to interview you in your own home approximately eight weeks following your discharge from hospital. Enclosed with this letter is an information sheet which you may like to read.

After your operation I will visit you to discuss any queries you may have. If you are willing to be included I will arrange a date to visit you at your convenience. If you feel you would rather not be involved you have every right to refuse and it will have no effect on your future care or treatment.

Yours sincerely

Lynne Henshaw

Appendix 3

RESEARCH STUDY INFORMATION SHEET

Researcher: Ms Lynne Henshaw RGN RNT BA

Q. What will participating in the study involve?

A. You will be required to take part in one interview in your own home approximately eight weeks following your discharge from hospital.

Q. Who will interview me?

A. Lynne Henshaw, a registered nurse conducting the research, will carry out all the interviews herself.

Q. How long will the interview take?

A. Approximately one hour.

Q. What will happen if I refuse or want to stop part way through the interview?

A. Your wishes will always be respected with no effect to your care in any way.

Q. Will I be identified in the study?

A. All information will be confidential. Your name will not appear in any report of the research study.

Appendix 4

CONSENT TO PARTICIPATE IN RESEARCH STUDY

RESEARCHER: Ms Lynne Henshaw RGN RNT BA

I have been asked to take part in a study investigating differences in women's experiences of recovery from gynaecological surgery.

I understand this involves an interview with the researcher approximately eight weeks following my discharge from hospital.

In reporting the findings of the study, I understand I will not be identified in any way.

I consent to participate in this study

Signature.....

Date.....

Interview date..... Time.....

Interview schedule - nurses

What sort of information do you believe women require when undergoing a hysterectomy?

Do nurses have a role in providing explanations about what a hysterectomy is and what is involved?

How do you prepare patients for going home?

(If you use leaflets) are verbal explanations necessary?

Does the nurse have a role in providing information regarding the menopause and HRT?

Does a woman's social class position affect the sort of information you give her?

How do you determine whether a woman is working or middle class?

Appendix 6

Interview schedule - Doctors

What sort of information do you believe women require when undergoing hysterectomy?

Whose role is it to give this information?

Who would make the decision as to whether a woman's ovaries were removed?

(If the women) What sort of information do they require for this?

What sort of information should be given to women about HRT ?

Who should make the decision as to whether HRT is prescribed following removal of a woman's ovaries?

Does a woman's social class position affect the sort of information you give her?

How do you determine whether a woman is middle or working class?